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**Exploring perceived early family relationships and
current relationship patterns in women who over-eat:
a qualitative study.**

**A thesis submitted in partial fulfilment of the requirements of the Open
University for the degree of Doctor in Clinical Psychology.**

March 1999

Salomons

Canterbury Christ Church University College

20,000 words

AWARD DATE: 5th May 1999

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Acknowledgement

This enables me to reflect on the experience of the dissertation and to be able to think about the many different individuals who have helped me to make it possible.

I would like to thank the women who shared their memories and experiences and made an interesting and thought provoking study. I would like to thank Marie Williams from the Eating Disorder Unit who gave me permission to seek participants, but also met my ideas with interest and enthusiasm. Additionally, I would like to thank Jan Prior and her colleagues who found me accommodation to interview the women.

I would especially like to thank Dr. Sue Holttum for her continual support, expertise, humour and encouragement. I would also like to thank Dr. Rudi Dallos for his on-site help and enthusiasm. I would like to thank Dr. Rachel Williams for listening, her energy and warmth, and for her interest throughout the study.

On a personal note, I would like to thank my friends, Amanda Shirtcliff, Maxine Falconbridge, Alan Velecky and Dionne Joseph for their endless support and for helping me think about things in a different way.

Finally, I would like to thank Paul and Harry, for their patience and love, without which, this would not have been possible.

Abstract

Objectives:- This study attempts to address the lack of systemic research on over-eaters. By focusing on women's perceptions, the study aims to develop understanding of the significance that early and ongoing relationship patterns have on their experience of over-eating.

Design:- The study used a qualitative research design based on Strauss and Corbin's (1990) grounded theory approach.

Method:- Twelve women participated, all had been referred to an Eating disorder unit and had received individual or group intervention. Face-to-face interviews were conducted using a semi-structured interview schedule. The interviews aimed to gain an understanding of women's perceptions of their early and ongoing relationships, perceived level of support in significant relationships (other than family) and relationship with food.

Results:- Grounded theory was used to analyse the participants' responses. Codes, categories and themes were generated from the collected data.

Conclusions and implications:- A tentative theoretical framework was developed from the participants' responses to the research questions. The data suggest that women perceive their early and ongoing relationship with their mother as compliant in nature. It also suggests that their father was

physically and/or emotionally absent. Additionally, women perceived that in the early family environment there was a high focus on food. Six women also perceived a lack of emotional support from their partners and sought food to comfort themselves. Eight women attributed their early eating behaviour to their difficult relationships with their father or mother.

An integrative framework has been proposed to account for the data.

Clinically, the results indicate that a systemic understanding and intervention should be considered when working with this client group. The researcher has addressed ethical and transference issues, methodological and conceptual issues and suggested ideas for future research.

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Chapter 1 - Introduction

1. Introduction

1.1 Overview

This study addresses an apparent gap in the literature on the psychological causes and correlates of over-eating behaviour in women. Much of the literature that exists is predominately concerned with medical and behavioural treatments of over-eating and fails to address the emotional aspects of the eating behaviour (Tucker and McNamara, 1995). The researcher draws upon the literature in the area of anorexia and bulimia to explore both the emotional and familial issues associated with eating disorders in general, and applies these to over-eating specifically. Some research has been carried out on the origins of, and interventions aimed at over-eating, but it appears to be treated as one of a number of other excessive behaviours (Orford, 1985) rather than conceptualising it as a distinct phenomenon.

This introduction will briefly look at definitions of eating behaviour and the limitations of current psychological research and treatment methods. The models of origin and maintaining factors of eating disorders will be reviewed. This will include biological and genetic perspectives, appetitive behavioural, social/environmental, psychodynamic and systemic perspectives.

Women's disturbed eating symptoms (in the context of anorexia and bulimia) have been found to be related to 'family of origin' functioning: specifically to perceptions that their families are low in cohesion and high in conflict. Such families have repeatedly been found to be more chaotic, disengaged, rigid, and indirect in communication than families without an eating disordered member (Johnson and Flach, 1985).

Most studies to date have assessed daughters' perceptions of mothers and their relationships with them. Fathers are often excluded. Despite an increased focus on family intervention in the treatment of eating disorders, the family therapy field has been slow to address the problem of obesity and over-eating behaviour. Although specialists in the treatment of obesity have suggested that family involvement is likely to produce better results in treatment, (Brownell, Kelman, and Stunkard, 1983) there has been a gap of nearly 50 years from Bruch's pioneering work on family systems and obesity (Bruch and Touraine, 1940, cited in Doherty and Harkaway, 1990).

There are several possible explanations for the lack of attention to the family treatment of obesity and the relative lack of research specifically addressing the psychological components of over-eating:

- (a) confusion over whether the problem is medical or behavioural;
- (b) debate over genetic versus environmental aetiology;
- (c) the chronic, seemingly hopeless nature of the problem;
- (d) high relapse rates after treatment;

- (e) cultural biases against obese people and the moral stigma of over weight;
and
- (f) the complexity of the problem itself.

Although there need to be better long term treatments, if the factors causing or maintaining over-eating are not identified, then development of the most appropriate treatment will be hindered. Before outlining current interventions aimed at dealing with over-eating, it is necessary to attempt a definition of over-eating behaviour.

1.2 Defining features of over eating behaviour.

Within the DSM IV (1994) binge-eating disorder is included within the eating disorders categories. However, this categorisation does not seem adequate because many women who experience over-eating or obesity would describe themselves as continually eating throughout the day, not necessarily for particular periods. Hooker and Convisser (1983) offer varying definitions that (the researcher feels) are more helpful for the present study.

Compulsive eater

The compulsive eater uses food as a constant coping mechanism, independent of biological hunger.

Binge eater

The binge eater is someone who carefully plans and organises the consumption of large quantities of food. The planning and eating tend to be

ritualistic, and secretive. Binge eating behaviour occurs among obese, bulimic and anorexic people.

Low- grade eater.

The low- grade eater has food accompany them through much of the day. They use food to supplement whatever they are doing and frequently take food breaks.

The researcher feels that definitions based on an over-eater's weight and body mass are not always helpful in considering psychological intervention. This is because the degree of obesity is not directly related to the personally perceived severity of the problem or its social and psychological implications. Additionally, on their own, weight and body mass do not discriminate between bulimics and over-eaters. (Doherty and Harkaway, 1990). For these reasons, weight and body mass will not be discussed at length .

1.3 Models of causality and maintaining factors in disorders of eating behaviour.

This section will briefly review biological and genetic, appetitive behavioural, social/environmental and psychodynamic perspectives on eating disorders. As there is limited research on over-eating behaviour and obesity, especially in systemic perspectives, research which considers anorexia and bulimia will

be drawn upon to enable the reader to consider some of the interactional patterns that may occur in women who experience over-eating.

1.3.1 Biological and genetic perspectives

Ganley (1992) reports on Herman and Polivy's restraint eating model (1975).

The restraint theory presents obesity as primarily the result of biological forces that cause an individual to be stuck at a high "set point" for body weight. Ganley suggests that many individuals, because of social pressures for thinness, attempt to push down their set point by dieting. The physical and psychological strain of controlling their eating predisposes restrained eaters to loss of control, with a consequent pattern of erratic eating behaviour and weight lability. The strain from this endeavour is also seen as causing them to be hyperemotional, such that emotions can disrupt the cognitive control and bring bouts of emotional eating.

Wilding (1997) states that doctors readily accept the need to treat the consequences of obesity, but obesity itself is often ignored because available treatments are considered ineffective or unsafe. He reports that there is now good evidence that the tendency to develop obesity is inherited. A study of 540 Danish adoptees suggests a strong relationship between the weight of adoptees and their biological parents (Stunkard, Sorensen, Hanis, Teasdale, Chakraborty, Schull and Schulsinger, 1986). They believed that childhood family environment appeared to have little or no effect on adult weight.

Treasure and Holland, (1995) on reviewing the genetic predispositions, found that there was a clearer link with anorexia than with bulimic sufferers. They did not consider obesity or over-eating in their review but criticise twin studies involving bulimia on methodological grounds. However, Crisp (1988) suggests that obesity occurs across generations of families, with a higher rate of occurrence within families than in the population as a whole. Strober and Humphrey (1987) disagree, and indicate that there is limited evidence that eating disorders (especially anorexia) have a familial link. However, they indicate that the available data do not make it clear whether genetic or environmental factors are more important, but suggest that the home environment influences adaptive and deviant patterns of self-esteem, identity and coping behaviour.

1.3.2 Appetitive Behaviour Model.

Particular attention has been given to the pattern referred to as 'compulsive' eating. Wilson, (1993) suggests that 'compulsive eaters' show extreme preoccupation with food and weight, episodically consume enormous amounts of food in short periods of time, and experience guilt, shame, depression, and self condemnation following 'binges'. Individuals report feeling 'out of control' with their eating, and experience a compulsion to consume food, in much the same way as a compulsive drinker would consume alcohol (Orford, 1985).

Wilson (1993) suggests that compulsive eating can be seen as an addiction, that some individuals are biologically vulnerable to certain foods that can

cause dependence, and that treatment must begin by interrupting the abuse of food. He recommends the 12-step program-Overeaters Anonymous that is modelled from Alcoholics Anonymous (Yeary, 1987, cited in Fairburn and Wilson, 1993). However, a range of medication has been prescribed to control excessive eating, as they have for all forms of excessive appetitive behaviour. The most popular for excessive appetites has been amphetamine-like stimulants used to suppress appetite. There seems to be agreement that amphetamines are moderately effective in controlling appetite (Ley, 1980) but their long-term efficacy is doubtful (Orford, 1985) and they can put the person at risk of developing another addictive behaviour.

Wardle (1987) suggests that the most successful treatment is Cognitive Behavioural Therapy (CBT) which includes self control techniques and relapse prevention. However, CBT has been criticised for its emphasis on controlling consumption, not on the development and maintenance of binge eating (Wilson, 1993).

1.3.3 Social /environmental perspectives

Tucker and McNamara (1995) theorise that mothers and fathers are likely to have their own abnormal conflicts with eating and a preoccupation with body image. They may value controlled eating behaviour and therefore abide by certain rules and routines surrounding food, bringing about a high focus on food in their lives. Anon (1987) found that young children and adolescents learn to acquire and retain the food preferences of their parents. Hill, Weaver, and Blundell (1990) support this argument and suggest that

parents' attitudes to weight and dieting are conveyed to and accepted by their children from an early age. They found that there was a strong correlation between mothers and their ten year old daughters in their motivation to diet. Furthermore, highly restrained daughters and mothers share a susceptibility to the disinhibitory effects of negative mood states, an effect described both in adult dieters and bulimics. They suggest that the reasons for this familial association are diverse and reflect the operation of both genetic and environmental variables, such as weight status, propensity to gain weight, food preferences and family economics.

Steiger, Stotland, Trottier and Ghadirian (1996) also report a gender related effect on eating concerns and symptoms. They found a close correlation between daughters and mothers, but not between daughters and fathers. They argue this may be connected with the central role that mothers have in conveying eating and body weight attitudes to their children. The children pick up these roles and attitudes to food through social learning. However, Steiger et al (1996) did not find evidence of attitudinal abnormalities in parents of clinical eating disorder sufferers.

Giving or withholding food is a family's easiest and most frequent method of behaviour modification. Some parents use it to reward, punish or alter a child's behaviour. Maine (1993) believes that in this way children can unconsciously engage in battles over food in order to gain some influence in their families.

1.3.4 Psychodynamic perspectives

Historically, mothers have been targeted in object relations explanations of eating disorder development, which may result in them feeling blamed or guilty (Maine, 1993). Mothers are often described as over protective, infantilising or intrusive, and tending to impose their own needs on the child. Fathers are said to exhibit egocentricity in their exertion of power and control in the family and in using their daughters to satisfy narcissistic needs (Tucker and McNamara (1995). Psychoanalytic theory of eating disorders (anorexia and bulimia) describes mothers as alienated emotionally from others, distant, emotionally controlled, and unable to provide emotional warmth and security to their daughters (Bruch, 1973).

Bruch (1973) suggests that fathers are also perceived as emotionally distant, rigid and superficial in relating to their daughters. Maine (1993) reports that women who grow up without a positive connection with their fathers suffer tremendously from their father's lack of attention. They do not experience that they have satisfied their father's needs, demands and expectations, because they have not received positive responses or approval from him. Maine calls this 'father hunger'. However, this is theoretical and not evidence based.

Hooker and Convisser (1983) consider women's over-eating behaviour as a way to cope with uncomfortable feelings which are related to difficult aspects of their lives. These authors believe that women's emotional fulfilment comes

through giving to others. In such situations, where the women is the caregiver and nurturer of others' needs, her own needs remain unfulfilled. Under these conditions, Hooker and Convisser believe that women turn to food either to repress their needs or to comfort themselves in some way. This point is supported by Bruch (1973) who talks about the symbolic significance of food in the sense that food conveys many messages that women otherwise find difficult to express.

Hooker and Convisser (1983) state that although women who consider themselves fat might be turning to food for similar reasons as an anorexic or bulimic woman, their fat may serve additional purposes. They suggest it may be used in the following ways:

- As a protection against being hurt (fat is a protective layer between the inner self and the outer world).
- As a means of feeling powerful.
- As a way of being taken seriously (having substance is associated with being large, and emptiness and shallowness are associated with being thin).
- As a form of communication (the fat states something that is too difficult to express).
- As an explanation for failure or rejection.
- As a distancer from personal and intimate relationships.
- As a mechanism for lowering others' expectations (no one expects much from fat people).

- As a way to maintain the status quo (I can't change anything until I'm thin).

Hooker and Convisser based their hypotheses on their clinical treatment of obese females in group psychotherapy and describe a self-perpetuating cycle whereby the more awful some women feel toward themselves, the more necessary it becomes to push these bad feelings onto their despised bodies. They argue that it is difficult for such women to see that aspects of their lives other than their relationship with food contribute to their feeling of inadequacy. Women often avoid these issues and the feelings associated with them by turning their attention to eating and the size of their bodies.

Many women experience discomfort when they feel angry and find it hard to express it. For some, anger can feel like a sensation in the stomach that is often misinterpreted as hunger. For others, it is less focused and is a generalised uncomfortable feeling (Hooker and Convisser, 1983). They suggest that for many, turning to eating in the face of anger is familiar, predictable and safe. Food is used to remove the focus from their troublesome feelings, therefore their focus is not on the angry feelings but on the food. Abnormal eating defensively shelters the over-eater from the internal anxiety resulting from aggressive conflict. However, anger not appropriately expressed but turned inward results in some form of depression and perpetuates a cycle of guilt and self-deprecation (Mills, 1994). Hooker and Convisser (1983) suggest that in this way, women learn to "stuff down" the feeling or "swallow" the anger. Mills (1994) suggests that in the same way women use food in response to many emotions and needs as a defence.

They might eat when they need nurturance, love, affection and intimacy.

Food becomes the buffer between women and feelings, which they find difficult to accept, and against needs that remain unfulfilled.

Mills (1994) believes that food becomes associated with security, trust, and oral-relational fulfilment that the maternal figure did not provide. Repeated and prolonged parental inconsistency fortifies this association over time. In addition, the strength of the maternal food association may become reinforced in the predisposed obese individual because the parent may use food as a means to satisfy the infant's needs for emotional responsiveness and to relational demands. Mills believes that once this dynamic is established food and eating remain a focus throughout the child's development. She argues that early experiences establish food as the only area which can be reliably depended upon and trusted. She suggests that food is a substitute object for parental and environmental responsiveness.

However, Dare and Crowther, (1995) believe that it is difficult to make conclusions about psychodynamic models of eating disorders because they are not empirically derived by formal experimental techniques.

1.3.5 Systemic perspectives

The strongest advocates of family models of eating disorders have understandably come from the field of family therapy. The family is viewed as a complex social system in which the various family features are seen as part of a complex matrix of interacting factors, in which the eating disorder is

somehow embedded. Causality is seen as a circular rather than a linear process.

The most comprehensive account of families of eating disordered clients comes from the work of Minuchin, Baker, Rosman, Liebman, Millman and Todd (1975). They developed a model of the so-called "psychosomatic family", with anorexia as a prime example. This model has three factors:

- i) The child is physiologically vulnerable
- ii) The child's family has four transactional characteristics: enmeshment, overprotectiveness, rigidity, and a lack of conflict resolution.
- iii) The child plays an important role in the family's pattern of conflict avoidance; and this role is an important source of reinforcement for their symptoms (Minuchin et al, 1975).

Looking at the four transactional patterns more closely (ii), *enmeshment* is the characteristic pattern of over-involvement and blurring of boundaries at the individual, subsystem and family levels. *Overprotectiveness* is the high degree of concern on the part of the family members for the welfare of other family members, which is not limited to the welfare of the index client. *Rigidity* is the tendency to maintain the status quo, even in situations calling for flexibility, change, and growth. Lastly, the *lack of conflict resolution* refers to the family's low tolerance for the expression of conflict, in particular between the parents. Occasionally, this takes place as overt conflict, which is never resolved. More typically, there is no or little expression of conflict, so the resolution is impossible.

Mothers of anorexics were commonly described as intrusive, over protective, anxious, perfectionistic, and fearful of separating from their children. Fathers were commonly described as emotionally constricted, obsessional, moody, withdrawn, passive and ineffectual (Minuchin, Rosman and Baker, 1978).

Eisler (1995, cited in Szmukler, Dare, & Treasure, 1995) states that the family systems accounts by Minuchin and others are clinically persuasive and provide important insights into family dynamics, but the empirical evidence in support of these accounts is limited. However, Humphrey (1986) has reported on a series of well controlled studies that suggest that the binge-purge cycle of bulimia is a metaphor for pervasive and chronically recurring family-wide deficits and excesses. Just as the bulimic periodically craves food during a binge, the bulimic and her family repeatedly crave and attempt to solicit nurturance, soothing, and empathy from each other. Similarly, family members are conceptualised as purging themselves by expelling their aggression and frustration toward one another without structure, focus, or resolution.

Johnson and Flach (1985) found that bulimics perceived their families as less cohesive, expressive, and active in recreation and as more conflictual when compared with the perceptions of non-eating disordered women, on the Family Environment Scale (FES, Moos and Moos, 1980) and the Family Adaptability Scale (Olson, Bell, & Portner, 1978). Results indicate that bulimic subjects perceived their families as having a great deal of unexpressed anger and conflict. Stern, Dixon, Nemzer, Lake, Sansore, Smeltzer, Lantz and

Schrier (1989) , also using the FES, compared 20 restricting anorexic, 13 bulimic anorexics, 24 normal weight bulimics and 57 control subjects.

Findings indicated that eating disordered families were less supportive of one another and less expressive of feelings than the families in the control group.

Using these measures, Humphrey (1986) found that bulimic-anorexic family members perceived their relationship as less involved and supportive and as more isolated, conflictual, understructured, and detached than did control subjects. Strober and Humphrey (1987) believe that bulimia reflects an unfulfilled craving for nurturance and a remedy for intensely painful feelings of rejection and loneliness, associated from a lack of parental affection, an overly negative and a disengaged pattern of family interaction.

Tucker and McNamara (1995) suggest that mothers whose daughters develop disturbed eating attitudes and behaviours have their own disturbances in object relations, specifically insecurity in attachments. This suggests that these mothers may be sensitive to rejections, easily hurt, and desperate for closeness. There is also some evidence to suggest that there is a pattern of parental obesity in families of the bulimic sufferer (Garner, Garfinkel, and O'Shaughnessy, 1985).

Maine (1993) addresses the negative aspects that many theories appear to identify in the maternal role. She suggests this is because the mother's central role is of feeder and nurturer. However, Maine (1993) believes that although the mother/child relationship is very powerful and may be

problematic, many other factors also contribute. These include the functioning and emotional tone of the whole family system, the role of the father and the marital relationship, and the social and cultural context in which the family lives. Maine suggests the family system echoes this value system by the roles, rules, and relationships which reflect the cultural context, and thereby transmit social expectations, attitudes, and interactional patterns.

Hill and Holbeck (1987) noted in a self-report study that adolescent girls (who were anorexic) said they experienced less acceptance from both parents, more parental control, and more disengagement on the part of their fathers. Sights and Richards (1984) interviewed six bulimic females and six control subjects with no prior history of an eating disorder. Based on the interviews, fathers of bulimic subjects appeared more emotionally distant from the daughters than fathers of the control group. Additionally, mothers of bulimics were judged to be more controlling and domineering than mothers of control subjects. White (1992) believes that binge eating not only results from practising dietary restraint but may be a way to relieve anxiety. The anxiety often results from feelings of inadequacy related to a lack of independence or individuation and the emotional separation issues.

Ganley (1986) presented a family systems model of obesity that adapted Minuchin's work to adulthood obesity. The adaptation used systems concepts and information from a literature review of emotional influences on eating. The model hypothesises that obese families are characterised by enmeshment, rigidity, over-protectiveness, and a lack of conflict resolution,

and the obesity is involved in family interactions in ways that encourage its maintenance and /or development. The model focuses on the need to study marital relationships, on the importance of interactions involving anger and assertiveness, and on affect-reducing functions associated with obesity that help stabilise family functioning. The family model also focuses on family characteristics and emotional processes. Generally speaking the symptoms are maintained or reduced to the extent that they serve relationship system functions. Although the emphasis is on the family as the unit of investigation, the model does not present the family as a closed system. Like Maine, Ganley emphasises that aspects of societal systems, such as cultural attitudes, social economics, and obesity treatment organisations, and of intrapersonal systems, such as physiology, genetics, and biology must be considered in a comprehensive systems model of obesity. Ganley states that his family model is a submodel of the larger systems perspective, that allows attention to be focused on what are believed to be the extremely important influences of the family.

1.4 Limitations of current psychological therapies.

This section will look at therapies generally offered to women who experience over-eating behaviour. These usually include individual behavioural, cognitive-behavioural and group work. Systemic therapies offered to sufferers of anorexia and bulimia will be reviewed briefly before looking at relapse prevention work, which aims to address the poor long- term outcomes and maintenance of weight loss.

1.4.1 Behavioural therapy

Behavioural therapy has been used in the management of obesity for many years (Staurt, 1967, cited in Bruch, 1973). The programme is based on the belief that obesity is a 'learned behaviour', which it is possible to cure by 're-learning' appropriate eating habits. However, successful long-term results have not been achieved (Brownell and Wadden, 1991). Behavioural therapy of obesity is based on the concept of bad eating habits, in which insufficient control of stimulus or rewarding behaviour results in increased food intake. Brownell and Wadden (1991) suggest that there is greater success when cognitive therapy is included in the treatment.

1.4.2 Cognitive behavioural therapy (CBT).

There is some evidence to suggest that cognitive behavioural therapy may improve the chances of long term success with weight loss (Skender, Goodrick, Del Junco, 1996). Treatment includes helping women become aware of hunger, slowing down eating and focusing on how one's stomach feels, self monitoring by keeping detailed eating records, and praise when meals are eaten at regular intervals in the day. The idea is that through practice and reward, changes in key areas of cognitive processing will result in behavioural changes.

However, there is evidence to show that over-eaters continue to relapse after this treatment, and long term success is poor (DeSilva, 1995). It would

appear that cognitive methods do not take account of the emotions that women experience when they over-eat or take into account the origins of the problem. However, cognitive behavioural models have been more helpful in treating bulimia. Fairburn, Cooper and Cooper (1986) were influential in shaping the understanding and treatment of bulimia, but perhaps the most comprehensive cognitive behavioural model of bulimia was from Wilson (1989). He includes cognitions, fear of weight, dieting practices, binge eating, purging and the post-purge psychological effects. However, there are limitations. Not all restrained eaters develop bulimia and it is obvious that many other variables play an overall role in determining whether someone develops bulimia or not.

However, to date there seems to have been insufficient attention paid to the aetiology of over-eating. This may have negated the possibility of more effective application of CBT. This would refer particularly to the schema-based components that are addressed in CBT for depression, for example. Evidence from CBT of depression suggests that tackling these longer-term components enhances outcome (Beck, Rush, Shaw, and Emery, 1979). By their nature, cognitive behavioural models focus on proximal causes and maintenance variables. They do not explain why some dieters will develop a disordered eating pattern such as bulimia or anorexia, while others do not.

1.4.3 Group therapy.

Blair, Lewis and Booth (1992) suggest that the lack of success in traditional weight control therapies is attributable in part to not enabling individuals to deal with problems of low self-esteem. The same authors had some success with group work, providing written handouts to strengthen personal effectiveness and self-esteem. It seems that working in small groups with others who share similar problems can create an environment where many women are able to shed feelings of shame and hopelessness (Hooker and Convisser, 1983). In addition, listening to other women share their experiences with eating, seems to help women feel less isolated about their own relationship with food. It can provide them with a group of peers who take them seriously and who understand their problems.

Hooker and Convisser (1983) believe that group work can create an opportunity for women to broaden their perspective about eating issues and give them a chance both to observe and contribute to solving others' problems. However, a pitfall for women in a group can be a focus on food and eating rather than on the emotional and social issues related to them. This focus can result in examining the symptom without dealing with the problem, thus perpetuating a cycle of avoidance. Additionally, whilst women are attending group therapy they are supported by the facilitator and peers. However, many women report that they can not sustain weight loss and changed eating patterns once the therapy is over, and are left feeling unsupported and alone again (Hooker and Convisser, 1983).

1.4.4 Systemic therapy

An extensive literature search uncovered a lack of literature on the effect of family therapy for women who experience over-eating. Generally, there are clinical case studies that advocate good results when systemic therapy is offered to eating disorder sufferers (Dare, 1997), but these are not empirically based. However, there are some studies, with long term outcomes concerning both anorexia and bulimia. Russell, Szmulker, Dare and Eisler (1987) followed 80 anorexic clients who had received an inpatient feeding programme. Those with early onset (before the age of 19 years) and a history of less than three years fared much better at one year follow up, if they had received family therapy as opposed to individual psychotherapy. The findings of this study were confirmed in a five year follow up study (Russell, Dare, Eisler and Le Grange, 1992).

There is less empirically based literature concerning the effectiveness of family therapy and sufferers of bulimia. However, Dodge, Hodes, Eisler and Dare (1994) reviewed the usefulness of family therapy in bulimia in adolescence. The results suggested that family therapy with this age group can be an effective treatment. However, Dodge and his colleagues did not include a comparison treatment group, so firm conclusions are problematic.

1.4.5 Relapse Prevention

The term 'relapse prevention' has been used to refer to a specific set of techniques advocated by Marlatt and Gordon (1985) in relation to intervention for addictive and appetitive disorders. The most common form of

relapse prevention has involved the supplementation of an initial intervention with booster sessions. Marlatt and Gordon's relapse prevention approach consists of a number of specific components such as identification of high risk situations, rehearsal of coping skills, preparation for lapses (to prevent them becoming relapses) relapse-crisis debriefing, and lifestyle modification. A major feature is the notion that the maintenance period is an opportunity for practice of newly acquired self-control strategies. Thus, clients are prepared for any lapses in advance of their occurrence through cognitive and behavioural methods. Clients are taught skills to cope with negative emotional states such as anger, anxiety and depression, interpersonal conflict, and social pressure to consume. Self-instructional skills training, relaxation, stress management and assertiveness training may also be included.

There have been mixed reports on the effectiveness of booster sessions in the treatment of obesity. Brownell, Marlatt, Lichtenstein, and Wilson (1986) asserted that booster sessions have been used mostly with smoking and obesity and been consistently ineffective. However, Perri, McAdoo, Spevak, and Newlin (1984) evaluated Marlatt and Gordon's relapse treatment in the maintenance of weight loss. They found that at 12 months follow up the only condition that maintained its mean post-treatment weight loss was the one that received behaviour therapy, plus relapse prevention training and post-treatment contact.

The literature on the efficacy for treatment for obesity indicates that the best long-term results come from those treatments in which there is lengthy and comprehensive intervention, focusing on diet, self reinforcement, cognitive methods and exercise followed by intensive therapist assisted maintenance programmes such as that of Marlatt and Gordon. Nevertheless, the evidence for long term maintenance is modest (Wilson, 1996). This would suggest that in many instances consistent themes are being over-looked in the maintaining factors that continue to promote over-eating behaviour. Wilson (1996) states that women who have low social support, ongoing interpersonal difficulties and low self- efficacy are more likely to relapse into over eating behaviour.

1.4.6 Summary

Biological explanations of physiology and genetic predisposition obviously have an important part to play in the production of eating disorders. The evidence for social/environmental perspectives also appear to have a significant role in eating behaviour in the way in which food is eaten. The appetitive model views overeating as an addiction, where women have the compulsion to eat, which is out of their control. However, the emotional aspect of why women continue to overeat appears overlooked in these perspectives. This is addressed in the psychodynamic model, but this is criticised for 'mother blaming' and a lack of empirical evidence. It would appear that whatever the predispositions may be, eating disorders require maintenance factors. There is some evidence to suggest that these may be

located in ongoing relationships (Humphrey, 1986). This is an area requiring further investigation.

Long term maintenance of weight loss is generally poor after psychological interventions, whether individual behavioural, cognitive behavioural, or group work (Lewis, Blair and Booth, 1992). There has been some success with systemic interventions with sufferers of anorexia and bulimia. It is arguable that this reflects the involvement of relationship difficulties in maintaining the eating behaviour. However, it is difficult to draw firm conclusions, especially as relapse makes individuals hard to work with (Orford, 1985). It could be that most interventions do not include sufficient relapse prevention input, or do not involve ongoing relationships sufficiently or both.

Whether or not other family members are included in the treatment, their importance, both in relationships in the real world and as internal objects for the sufferer, should not be ignored. Gaining more research evidence on the impact of family relationship patterns on women who experience over-eating behaviour, may lead to other therapeutic interventions which offer greater short and longer term outcomes.

1.5 Research Aims

Detailed qualitative process research that examines women's experience of over-eating and their perception of early and ongoing relationships has not been done to date as far as the author could determine. Therefore, analysis which looks in depth at women's individual experience and their understanding of over-eating was considered to be most appropriate for the design of this study. In order to develop an understanding of women's experience of over-eating from a systemic perspective, this research explored the following areas:

- To compare over-eating behaviour with the familial literature on bulimia and anorexia.
- Whether a systemic model is useful in understanding over-eating.
- Whether there is a specific relationship pattern between women who experience over-eating and their mothers.
- Whether there is a specific relationship pattern between women who experience over-eating and their fathers.
- The ongoing relationships of women who over-eat.

In addition the researcher was interested in:

- How women's verbatim accounts inform clinical thinking.
- How issues of over-eating can raise psychological interest.

1.6 Choosing an appropriate methodology.

This present study only looked at women who experience over-eating behaviour. It is suggested by Kinston, Miller, Loader, and Wolff (1990) that men and women feel different as individuals and take up differing roles within the family and society. They suggest that more women may be more likely to have a disturbance in their physical and emotional identity than men. Given that more women appear to over-eat than men or certainly appear to seek professional help for their eating behaviour (Kinston et al, 1990), this present study decided to review women only.

Looking at the literature that exists on anorexia and bulimia that has used quantitative methods of research, and added to that the relative lack of research on over-eating, it might have been expected that this present study could have been carried out using already existing questionnaires. However, Szmukler, Dare, & Treasure (1995) suggest that there is a consistent finding with questionnaire methods within the eating disorder research, that differences that are found may apply only to highly selected clinical samples. Community based samples find little or no differences between eating disordered groups and controls.

For this research, the researcher wanted the participants to be able to tell 'their own story' about their early and ongoing family relationships, rather than provide a specific set of symptoms and historical data relevant to the interviewer. Charmaz (1995) states that grounded theory methods are useful for studying personal experience, emotions, interpersonal relations and

interpersonal conflict. All of these are significant within the present research study. According to Charmaz (1995), grounded theory offers simultaneous involvement in data collection and analysis of the research; the generation of codes and categories developed through the data rather than preconceived hypotheses. Additionally it provides for the development of theories, memo-writing and sampling for the construction of theory to enable assessment and refinement of the researcher's emergent conceptual categories.

Searight and Young (1994) state that:

"Qualitative inquiry is valuable when attempting to understand complex, natural phenomena that are not amenable to experimental control, when the goal of inquiry is to understand subjective experience, or as an initial stage of inquiry when studying a previously unresearched area".

They suggest that the complexity of family systems as well as the relatively new status of family medicine as a discipline, make qualitative methods a particularly 'good fit'.

Therefore, analysis which looks in depth at women's individual experience of over-eating, and their perception of early and ongoing relationships was considered to be most appropriate for the design of this study. Strauss and Corbin's (1990) approach to grounded theory was followed to analyse the interview material in order to examine the complex nature of the data both openly and flexibly.

Using an interview schedule provided the researcher with information about the women's experience in a focused way. It was hoped that in this way the women could express their experience freely to allow the key issues to emerge, giving the advantage that the researcher could be spontaneous and add further questions during the interview if the opportunity and perceived need arose.

Relying on the participant's perception of their family relationships could call into question the accuracy of the data. However, O'Kearney (1996) believes that models of attachment at a cognitive level include important memories of attachment related experience with significant members, attitudes, and expectations about the self and others in relation to relational patterns. Therefore gaining women's perception of their childhood would still provide useful representations of their childhood relationships with their parents.

1.7 Research questions

The principle of grounded theory is that research questions emerge out of the data collection process - consequently, hypotheses were not devised prior to data collection. The researcher hoped that other interesting and relevant material would emerge throughout the data collection and analysis.

The design of the interview schedule, completion of the interviews and data analysis, were guided by the following research questions:

- 1) How do participants' perceive their early parenting?
- 2) How do participants' perceive ongoing relationships with their parents?
- 3) How do women who continue to over-eat in adulthood perceive support from significant others (others than parents)?
- 4) How do women perceive their ongoing relationship with food?

Chapter 2 - Methodology

2. Methodology

2.1. Design

This was a study of a sample of 12 adult women who perceive themselves as 'over-eaters'. The study used a qualitative design, closely following the initial stages of the grounded theory approach described by Strauss and Corbin, (1990). It has the limitation that the method could not be fully developed, owing to restrictions of time. However, in justification of the method, this study was able to examine in detail women's experience of early and ongoing family relationships and the development of a preliminary model of over-eating behaviour. Womens' views concerning early family and current relationship patterns were elicited through face to face interviews using a semi-structured interview designed by the researcher. A qualitative approach was adopted to gain in depth understanding of women's views.

2.2. Participants

16 female participants were sought. Out of the 16, 13 voluntarily participated, and 3 declined. All were or had been NHS clients at a regional Eating Disorders Unit (EDU) where they had been classified as "over- eaters" rather than bulimic. One of the participants was excluded after interview because she experienced bulimic behaviour of bingeing and purging.

2.2.1. Inclusion Criteria.

Participants met the following selection criteria:

1. the presence and history of over-eating behaviour,
2. had attended or were attending the Eating Disorder Unit,
3. women over 16 years of age,
4. women who were not purging after eating.

The study excluded women who were pregnant as there is evidence to suggest that pregnancy can change over-eating behaviour because the woman feels 'full' (White, 1992).

2.2.2. The characteristics of the participants.

Individual participant details are shown in Table 1.

Participant's weight was not available but all had been identified by the EDU as 'over-eaters'.

2.3. Measures

2.3.1. Developing the semi-structured interview schedule.

A semi-structured interview schedule, (appendix 1) was designed by the researcher. This aimed to address the research questions. The development of the schedule drew upon the research literature to establish content validity in relation to likely contributing factors to over-eating behaviour. Specifically, in line with the principal aim of discovering the perceived role (for the women) of early and current relationships, questions concerning these issues were

included. To allow participants freedom to express their own views and understanding of the issues, the structure of the interview was deliberately kept flexible. This also allowed for the development of new questions during the course of the research (Strauss and Corbin, 1990).

Table 1: Participant details (names are invented to preserve anonymity).

Participant	Age	Marital status	Time since last attended EDU	Type of therapeutic intervention	Duration of intervention	Contact with parents	Number of children
Nancy	39	Married	Current	Individual Cognitive Behavioural Therapy (CBT)	12 weeks	Once a month	None
Mary	33	Married	Current	Group CBT	18 months	No contact	1
Tracey	30	Single	Current	Individual CBT	6 weeks	Every day	None
Maria	52	Married	Current	Individual Counselling	Two and half years	Mother-dead Father-weekly contact	2
Mandy	31	Married	Current	Individual CBT	Two years	Father-dead Mother-1-2 times a year	1
Penny	49	Divorced	13 months	Individual CBT	16 weeks*	Regular contact by phone, sees ¾ times a year	2
Wendy	42	Divorced	12 months	Group intervention	3 weeks*	Mother-dead Father-fortnightly contact	2 (not at home)
Jackie	40	Married	7 months	Group *	5 weeks*	Mother-weekly Father-dead	3
Angela	34	Married	4 months	Individual CBT	2 weeks*	Every 2-4 months	2
Jenny	31	Divorced	Current	Individual CBT	2 months	Every 3-6 months	1 (lost in custody battle)
Peggy	34	Married	Current	Individual CBT	12 weeks	Speaks to parents every few days.	1
Sandra	35	Single	Current	Individual CBT	3months	Mother-2-3 weekly Father-dead	1

*NB. These participants left therapy rather than being discharged by the EDU.

2.3.2. Piloting the interview schedule.

The interview was administered to two acquaintances of the researcher (see section 2.4.1), both of whom described themselves as over-eaters and were currently in psychotherapy, one individually and the other attending group psychotherapy. Both gave consent to be taped which enabled the researcher to listen and reflect on the interview style, and to reflect on her questioning and timing of the interview. They were asked to comment on the interview and question content and suggest recommendations regarding possible changes. Minor changes were made to the interview schedule from the piloted interviews, for example, questions referring to food being used as a punishment or reward were added.

2.3.3. Outline of the interview schedule.

An outline of the interview schedule is given below. The interview was divided into four sections. Questions were spontaneously followed by prompts where necessary, which aimed to further explore the answers to the questions in more depth.

Section 1: Demographic information.

Details were sought regarding the participant's background including their age, marital status, employment status and family circumstances/significant relationships (past and present).

Section 2: Family relationship patterns as an adult.

This section explored participants' feelings regarding their present relationship with their parents and partners. It also aimed to explore how family members supported each other, how they showed their affection and anger to each other.

Section 3: Family interactions around food and meal times remembered as a child.

These questions aimed to explore participants' memories of their early relationships with their parents and family. Questions included what memories the participant had of meal times and family eating patterns. The questions also aimed to elicit the women's explanation for any conflicts.

Section 4: Over-eating behaviour

This section explored the characteristics of the participants' over-eating pattern. Questions included what memories they had relating to different environments. It also aimed to explore what participants understood the cause to be of their over-eating pattern and what they believed kept the behaviour going. Additionally, questions explored women's feelings regarding food.

2.3.4 Researcher's feelings during interview.

During the interview the researcher attended to her impressions of the interview and the feelings aroused in her by the participant and noted them down after the interviews. This was done to aid the research diary keeping,

and also to allow the researcher to deal with her own issues raised by the feelings evoked in her by the participants.

2.4. Procedure.

2.4.1. General ethical considerations

Consideration was given to ensure

- that participants were able to participate voluntarily;
- that those who found the subject matter of the interview distressing could stop at any point;
- that all participants had a contact therapist at the EDU if any uncomfortable material surfaced during the interview.

The research was designed to follow the British Psychological Society's Ethical Principles and Guidelines (1993) and the Division of Clinical Psychology Professional Practice Guidelines (1995). The research proposal was scrutinised and formally approved by a local research ethics committee (see letter of approval in appendix 2).

Ethical consideration was given to the pilot participants. The researcher was concerned that it could be difficult to obtain the necessary numbers of participants for her study. Therefore using acquaintances who were receiving therapeutic help potentially appeared to protect them in case they found the

subject matter of the interview distressing. Although the researcher is aware that using acquaintances in her pilot study may bring into question her results, she feels assured that the pilot participants gave honest and constructive feedback to the interview schedule. This enabled the researcher to form clearer questioning.

2.4.2. Recruitment briefing procedures.

The researcher sought the consent from the EDU manager for the study to include clients who had or were attending her unit. Once their consent was established, the researcher met with other team members to explain the aims and rationale of the study. Consent was also sought from the Chief Executive of the Trust and was received (appendix 3 for letter of consent).

A participant information sheet (appendix 4) was developed which explained:

- the nature and purpose of the research;
- what the participant could expect from the interview e.g. time; subject matter;
- how confidentiality and anonymity would be addressed;
- how the participant could withdraw from the study at any time and
- that taking part in the study would not affect their care and treatment at the EDU.

The information sheet was sent to each potential participant by the EDU manager with an introductory letter written by her (appendix 5). The manager had been briefed by the researcher about the study. Each information sheet

had a cut off slip at the bottom of the page which, if the participant was interested in taking part in the study, she could fill in and return it in a pre-paid return envelope to the researcher. Additionally, if the potential participant wanted more information regarding the study, they were given a contact number for the researcher.

Participants who had indicated their willingness to participate, were then contacted by the researcher to make a convenient date and time to carry out the interview. Participants were briefed again by the researcher at the start of the interview (using the participant information sheet, appendix 4) to ensure that they fully understood the five points above. They were encouraged to ask questions about the research at this point.

2.4.3. Establishing consent

A standard consent form was designed (appendix 6). This was read to each participant and completed by the participant before the interview began.

2.4.4. Participant distress arising from the interview.

There was no expectation that the research would be distressing in itself, although the researcher was aware that the interview might uncover uncomfortable memories regarding relationships and feelings about over-eating. The researcher therefore was keen only to recruit participants who had or were under the therapeutic care of the EDU, therefore the participant could have access to a therapist if they needed to. If a participant became

distressed during the interview itself, she was asked if she wished it to stop at that point.

The interviews took approximately 1.15 hours to 1.45 hours. Responses given to the interview questions were tape recorded and then fully transcribed onto a computer.

2.4.5 Debriefing participants.

Participants were asked how they felt having completed the interview and whether there were any difficulties raised from participating. They were also asked whether they felt anything had not been covered. The purpose of the research was then reiterated and the participant was asked whether they would like a brief report on the study's findings.

2.5. Data Management.

The transcripts from the interviews were analysed using the grounded theory method described in detail by Strauss and Corbin (1990). These authors describe a process where data collection and analysis are undertaken simultaneously so that emerging material and analysis further shapes data collection. However, due to the time constraints in this study, the bulk of the analysis followed complete data collection.

Analysis was undertaken in the following ways:

2.5.1. Familiarisation.

This involved a process of reading and re-reading the typed scripts to become familiar with the content of the material.

2.5.2. Coding

Transcripts were analysed by attaching meaning to the text. Meaning was abstracted from the transcript creating a coding frame (appendix 7). As further transcripts were analysed, the codes were modified and extended to form new codes.

2.5.3. Categorisation.

This involved organisation of the information obtained from the coding process into categories, on the basis of similarity in meaning. These categories were then used to develop preliminary major categories to describe the main characteristics of the data. Each category was defined and illustrated by relevant quotations that illustrated meaning from the transcripts.

2.5.4. Thematic Analysis

Themes were identified to classify factors from the categories that were explored and developed from the data.

2.5.5. Construction of preliminary theory

The last stage of analysis aimed to construct a theoretical framework. This was based on the interpretation of the categories and the themes generated from the data.

2.6. Reliability and Validity.

2.6.1. Face validity

The semi-structured interview was developed through an extensive review of the literature pertaining to family systems theory and other literature on the factors contributing to the development of women's eating disorders and over-eating behaviour. Therefore, the measure has face and content validity and also ecological validity (Strauss and Corbin, 1990), as the material collected was closely grounded in participants' experiences and beliefs. The face and content validity was further enhanced by the pilot study.

2.6.2. Respondent validity

The two pilot participants were invited to comment on the emerging analysis. They were re-interviewed separately in order to determine the validity of the qualitative research and to what degree they could identify with the results (See section 3.3.1). This was done after the inter-rater reliability study on all the study's findings, not just their own analysis. Silverman (1993) suggests that respondent validity provides a forum for the researcher's interpretations to be judged.

2.6.3. Auditability

Throughout the study a research diary was kept by the researcher (appendix 8). This provided an account of the researchers subjective experiences and interpretative process of the research in relation to the participants' transcripts and allows this process to be scrutinised by others (Miles and Huberman, 1994). (See section 4.3.1).

2.6.4. Inter-rater reliability.

To determine the accuracy of the researcher's analysis, an independent rater was randomly allocated 2 of 24, (half text) 12 page (approximately) sections of transcripts. The researcher decided that giving the rater parts of text rather than short sentences from the text would enable the rater to get a feel for the content and allow greater continuity. Although rating in this way could potentially be harder for the rater, the researcher felt there would be greater reliability if the rater was not led in any way. They were given instructions to read the text and sort the content into the basic codes and categories generated by the researcher in response to the four research questions. Additionally, the researcher gave them a list of definitions that were pertinent to the text (See appendix 10).

Inter-rater agreement was calculated (results presented in the results section 3.3).

2.6.5. Generativity

The generative power and the clinical implications will be considered in the discussion. It has been suggested that the quality of research should be judged in this way (Henwood and Pidgeon, 1995). This is important to determine whether the findings of this study can be transferable to other contexts and theoretical networks. Miles and Huberman, (1994) distinguish generalising to "what is" to "what may be" to "what could be".

2.6.6. Rhetorical power.

Qualitative research can be examined by its rhetorical power. The quality and meaning of it is usually determined by how persuaded those working in the field are of the study's findings. The researcher has endeavoured to present suitable examples from the analysis to enhance the judgement of its validity by the reader.

Chapter 3 - Results

3. Results

3.1 Overview:

The initial analysis produced 188 basic codes which were grouped under the four research questions. From further analysis of the interview material these codes were further modified and grouped into 33 categories.

The emerging conceptual categories will be presented for each research question (with a full description of each in appendix 9). Quotations will be used to illustrate certain categories.

The results will focus on the relation of categories to the thematic analysis and generation of themes. The text will refer to the tables which list categories generated for each research question.

Outcomes of the inter-rater reliability study are then presented.

3.2 Presentation of Categories

The initial 188 generated basic codes which related to women's experience of over-eating and perceived early and present relationships, led to 33 conceptual categories. They will be presented in table form under broad groupings which were developed through the emerging thematic analysis. The categories will then be discussed in relation to these groups. The

number of participant responses to each category will be shown in a bracket beside each category.

3.2.1 Question 1: How do participants perceive their early parenting?

Table 2 shows the categories which developed to describe how participants perceive their early parenting. Twelve categories emerged in relation to this research question. These have been grouped together in terms of broad subject headings (presented in table 2 as 'broad groupings'). Following the table, exemplary quotes are provided for each grouping. **The number in the square bracket refers to the category within the table.**

Table 2: Categories identified relating to women's perception of their early parenting.

Broad Grouping (informing the emerging themes)	Conceptual Category (Number of participants).
Perceived powerlessness from parental relationship	1. Mother was controlling (8) 2. Relationship to parent was of a compliant nature (10)
Parents physically absent	3. Parents physically absent for periods of time (9) 4. Father physically absent at meal times. (9)
Emotional deprivation	5. Parents were unavailable emotionally (9) 6. Women were cautious to share personal material with parents. (5) 7. Women could not remember love and affection from parents. (8)
High focus on food within family environment	8. Women experienced rules at mealtimes (8) 9. Women experienced parents dictating food intake. (5) 10. Women felt deprived of food. (9) 11. Women experienced secret eating. (9) 12. Generational patterns of eating observed. (6)

i) Perceived Powerlessness from parental relationship

Eight of the women described their early relationships with their parents as powerless. This feeling came from their mother being perceived as controlling [category 1], and from their relationship with their parents being of a compliant nature [category 2].

Mary: *"We had to keep her calm, keep her nice, we complied to keep the peace"* [2]

Peggy: *"I felt controlled by her, she was so strict with all her rules and she domineered everyone. I couldn't do anything without her say-so".*

ii) Parents physically absent

Nine out of twelve women spoke about their parents being physically absent from the family home, when they were children. [category 3]

Jackie: *"My father was abroad a lot of the time"*

Maria: *"When my sister was born, I was sent away to a convalescent home in Worthing for three months. I did not see my parents for all that time".* [4]

Nine of the women remembered that their father was absent for mealtimes:

Mary: *"He (father) wouldn't be there for breakfast or tea, only Sunday lunch. We saw him for about an hour if we were lucky".* [4]

iii) Emotional Deprivation

Women described their early parenting as being emotionally deprived. Three quarters of them noted that their parents were unavailable to them emotionally. [category 5]

Jenny: *"They weren't interested in me, I felt an inconvenience to them, they never were there to listen to me".* [5]

Sandra: *"I don't ever remember having a conversation with my dad, he really wasn't bothered with us. I never felt there was a relationship with my dad."*

Nancy described a more specific cause of emotional deprivation:

"My younger sister died of cot death when I was five. My mother and father were very traumatised and they couldn't give me the attention I needed. I think they thought because I was the eldest I didn't need them so much, but I did." [5]

Peggy remembered feeling cautious about sharing personal material with their parents when she was a child:

"I'd have to choose my moment, I wouldn't feel comfortable doing it". [6]

Two thirds of the women could not remember love and affection being shown to them from their parents. A typical comment was:

Angela: *"I don't remember any cuddles".* [7]

iv) High focus on food within the family environment

The category of high focus on food was noted by many of the women in relation to their early parenting. Two thirds of the women perceived rules at mealtimes [category 8] and just under half of the women perceived their parents dictating their food intake. [9]

Wendy: *"You had to eat what you were given, but weren't allowed any more".*
[9]

Three quarters of the women felt deprived of food [10] and experienced eating in secret. [11]

Mary: *"My impression of childhood is that I spent a lot of it hungry".* [10]

Mandy: *"I used to help myself and then go somewhere and eat it".* [11]

Half of the women observed generational patterns of overeating in their childhood.[12]

Tracey: *"I used to find empty biscuit wrappers down the sofa cushions, where my mother had secretly eaten them herself".* [12]

3.2.2. Question 2: How do participants perceive ongoing relationships with their parents?

Table 3 presents categories that represent the women's perceptions of ongoing relationships with their parents. Eight categories were identified.

Table 3: Identified categories in relation to women's perception of their current relationship with their parents.

Broad Grouping (informing the emerging themes)	Conceptual Category (number of participant responses)
Controlling mother relationship	1. Women experienced their mother as controlling (8)
Perceived powerlessness from parental relationship	2. Compliant relationship with mother (5) 3. Avoiding conflict with parents (9)
Emotional Deprivation	4. Women feel rejected by their father (9) 5. Absent affection from parents (7) 6. Father emotionally unavailable (5)
Lack of Support	7. Absent support experienced from parents (10)
Identity as a woman	8. Arrested perception of women's maturation by father (2).

i) Controlling mother relationship

Comments highlighted the perception of the women's relationship with their mothers as being controlling in nature. [category 1]

Wendy: *"I find my mother's controlling involvement in my life too disruptive"* [1]

Nancy: *"She still tells me what to do, who to be with.."*

ii) Perceived powerlessness from parental relationship

The interviews picked up that women experienced a continued compliant relationship with their mother [category 2] and perceived that they avoided conflict in their relationship with their parents. [3]

Nancy: *"We have spent our lives trying to please my mother".* [2]

Maria: *"I go out of my way not to upset her".* [3]

Jackie: *"There's no way you could have a go at him".*[3]

iii) Emotional Deprivation

Three quarters of the women interviewed felt rejected by their fathers. [category 4]

Penny: *"He (father) fits us in around other things, his family don't come first".* [4]

Seven of the women expressed a lack of affection in their relationship with their parents. [5]

Mandy: *"He's (father) not a man to show affection, he never has".*

Just under half of the women commented that they continued to find their father emotionally unavailable to them. [6]

Jenny: *"I've never spoken on a one-to-one basis with him (father)".* [6]

iv) Lack of Support

The majority of women interviewed experienced a lack of support within their ongoing relationship with their parents. [category 7]

Mandy: *"My parents support me? I don't think they know how".* [7]

v) Identity as a woman

Two of the women experienced an arrested perception of their maturation by their father. [category 8]

Wendy: *"He still thinks of me as 10 years old and treats me accordingly, in a world where you haven't grown up"*

Mary: *"His perception of me hasn't moved on".* [8]

3.2.3 Question 3: How do women who continue to overeat in adulthood perceive support from significant relationships (other than parents)?

Table 4 presents the categories that describe the perceived support women experience from relationships (other than their parents). Six categories were identified.

Table 4: Identified Categories in relation to women's perceived support from significant relationships (other than parents).

Broad Grouping (informing the emerging themes)	Conceptual Categories (number of participants)
Supportive	1. Partner supports them domestically (4) 2. Partner supports them emotionally (3) 3. Partner supports them financially (3)
Emotional Deprivation	4. Partner does not show love/affection (6) 5. Partner does not support women emotionally (6)
Conflict Avoidance by partner	6. Partner does not show anger (5)

i) Supportive

A third of the women felt supported domestically by their partners [category 1]
and a quarter felt emotionally supported. [2]

Mary: *"He helps around the house and with our daughter".* [1]

Mandy: *"He (partner) never criticises or complains, he's always there for me".*
[2]

ii) Emotional Deprivation

Half of the women interviewed described a lack of emotional support by their partners [category 4] and a lack of love and affection shown to them by their partners [3]

Participants offered the following comments:

Angela: *"He (partner) doesn't understand what I need or what I'm feeling".* [4]

Nancy: *"Sexually, our relationship is not what it used to be".* [3]

iii) Conflict avoidance by partner

Five of the women reported that their partners avoided conflict and did not show anger or upset. [category 5]

Jackie: *"He (partner) doesn't show his anger, he doesn't like showing his feelings"* [5]

Peggy: *"When he (partner) gets mad, he runs upstairs and shuts himself away, or goes for a run".*

3.2.4. Question 4: How do women perceive their relationship with food?

Table 5 presents the categories that represent women's perceived relationship with food. Seven categories were identified.

Table 5 Identified Categories in relation to women's perceived relationship with food.

Broad Grouping (informing the emerging themes)	Conceptual Categories (number of participants)
High focus on food	1. Memories of food at school (11) 2. Secret eating (10)
Emotional deprivation	3. Cause of overeating due to relationship with mother (5) 4. Cause of overeating due to relationship with father (3) 5. Cause of overeating due to life event (2) 6. Cause of overeating due to emotional (internal) feeling (8)
Environmental factors	7. Continue to overeat due to external causality (3)

i) High focus on food

Almost all the women interviewed had memories of food (either positive or negative) at school. [category 1]

Jackie: *"School dinners used to make me sick".* [1]

Mandy: *"I never felt I got enough".* [1]

Mary: *"Dinner monitor meant you could have seconds, I thought that was excellent"* [1]

Ten of the women described their experience of secret eating when they thought about their relationship with food. [2]

Peggy: *"I take food upstairs and eat it on my own while my husband is downstairs watching TV". [2]*

ii) Emotional Deprivation

Two thirds of the women describe their relationship with either their mother or father as being the cause of their overeating behaviour. [categories 3 + 4]

Maria: *"It was the rejection from my mother right from a baby and the lack of attention I got from her that made me look for comfort elsewhere". [3]*

Peggy: *"My dad never showed me any affection, and I think that's the basis of the problem". [4]*

Two women stated that they felt emotionally deprived due to a life event. [5]

Nancy: *"My sister dying, its not the fact that she died but what happened afterwards with my mum that is the root of my eating problem". [5]*

Two thirds of the women described emotional feelings that continue to cause them to overeat. [6]

Wendy: *"Its the nearest I get to comfort, so I eat". [6]*

Penny: *"I feel incomplete and emotionally empty, so I binge to feel full up, to feel contented". [6]*

iv) Environmental factors

Three of the women attributed external reasons to their experience of continuing their pattern of overeating. [category 7]

Jackie: *"If I've got company I can be really good, but if I'm alone, I eat more".*

[7]

3.3. The results of the Inter-rater reliability study (Appendix 10)

The independent rater was given instructions to read the text (see section 2.6.4) and sort the content into the basic codes and categories generated by the researcher in response to the four research questions. The independent rater did not generate codes anew.

1. How do participants perceive their early parenting?
2. How do participants perceive their ongoing relationship with their parents?
3. How do women who continue to overeat in adulthood perceive support from significant relationships (other than parent)?
4. How do women perceive their relationship with food?

Inter-rater reliability was then obtained by calculating the percentage agreement on code and category assignment for each research question.

Table 6 shows the inter-rater reliability for the codes.

Table 6: Results of inter-rater reliability for basic codes.

Research question in which codes were contained	Percentage Agreement
Question 1	78%
Question 2	87.5%
Question 3	83%
Question 4	77%

Table 7 shows high inter-rater reliability across the interviews for the categories.

Table 7: Results of Inter-rater reliability for the categories generated.

Research question in which the categories were contained	Percentage Agreement
Question 1	83%
Question 2	87.5%
Question 3	80%
Question 4	86%

3.3.1 Respondent validity results.

Detailed summaries of the categories (generated from the original interviews, appendix 11) were presented to the pilot participants individually. They were asked whether the accounts accurately reflected their experiences. In general, the categories did appear to reflect the pilot participant experiences accurately. Participants were asked to reflect on the themes and the diagrammatic representation of women's over-eating process (Figure 1, section 4.1). Both participants commented on the framework as relating to them, and said "*that could be me*". They both commented that until now, they had thought more about their mothers' lack of emotional involvement than the significance of their fathers' absence and its impact on their over-eating

experience. One woman spoke of her belief that her eating pattern could be changed with greater support from family and professionals.

3.4 The Thematic Analysis

The themes identified from the data are presented below. Themes were influenced by the board groupings used to present the categories in Tables 2 - 5 above. **The number of participant responses are shown in brackets.**

Controlling mother relationship

Participants described difficulties in their relationship with their mothers, both in childhood and within their ongoing relationship. The women described their mothers as "controlling" and "domineering"(8). Many described the compliant nature they had developed towards their mother as doing things to please her.

Conflict Avoidance

This theme refers to the relationships between the participants as children and now as adults; with their parents. The women described their early experiences in their family as avoiding upset (10) and avoiding conflict with their parents presently (9). Generally, this appeared to mean that women did not fully express themselves, in fear of being reprimanded and criticised, or upsetting someone.

Physically and/or emotionally absent father

Participants frequently experienced their early childhood without the physical and emotional contact with their fathers. Instances of physical absence included memories of fathers working abroad or being absent at meal times (9). The emotional absence was indicated by lack of interest in the women (as children), or not having a one-to-one conversation with their father (9).

Lack of Open Affection

Lack of affection was also felt to constitute an important theme across the research questions. It was seen by the participants as an important source of comfort that had been lacking both in their early (8) and ongoing relationships (7) with their parents. Additionally, many women expressed a lack of continual love and affection in their lives, not only as a source of their over-eating behaviour but as a continuing factor. Over-eating was seen as a way to gain comfort through means other than through love and affection within significant relationships.

Lack of Emotional Support

Participants (as adults) experienced a lack of support from their parents (10). Participants talked of domestic support from partners but there was an overriding feeling of a lack of emotional support throughout their lives. Women spoke of not feeling understood by their partners emotionally (6). The women were more likely to emphasise the role that emotional neglect in their early life had on their development of seeking emotional comfort through food. However, three women did perceive emotional support from their

partners, but did not indicate that this had in any way alleviated their over-eating pattern.

Emotional Deprivation

This theme emerged to link the categories that were suggestive of parental unavailability (9) and feelings of rejection by father (9). Unavailability was also perceived as an ongoing theme in significant adult relationships (6). Many women described feeling 'emotionally empty' (4), 'lonely' (5) and 'upset' (6), needing to over-eat to feel 'full-up' and 'contented'.

High Focus on Food

This theme emerged from the descriptions of family mealtime rules and rituals (8), many food-related memories from school (11), the amount of food being dictated by parents (5) and the observation of parental patterns of eating behaviour (6).

3.5 Superordinate Themes

It was decided that to understand the data and allow it to inform the development of a theoretical framework, several of the themes could be subsumed under superordinate themes, as they reflect similar theoretical concepts. Therefore, three themes were developed and are presented below:

1. Compliance

- (i) controlling mother relationship
- (ii) conflict avoidance

2. Emotional Deprivation

- (i) emotionally absent father
- (ii) lack of affection
- (iii) lack of emotional support
- (iv) emotional deprivation

3. High focus on food

- (i) father physically absent at mealtimes
- (ii) generational patterns of eating observed
- (iii) rules and routines concerned with food.

Chapter 4 - Discussion

4. Discussion

4.1 Outline

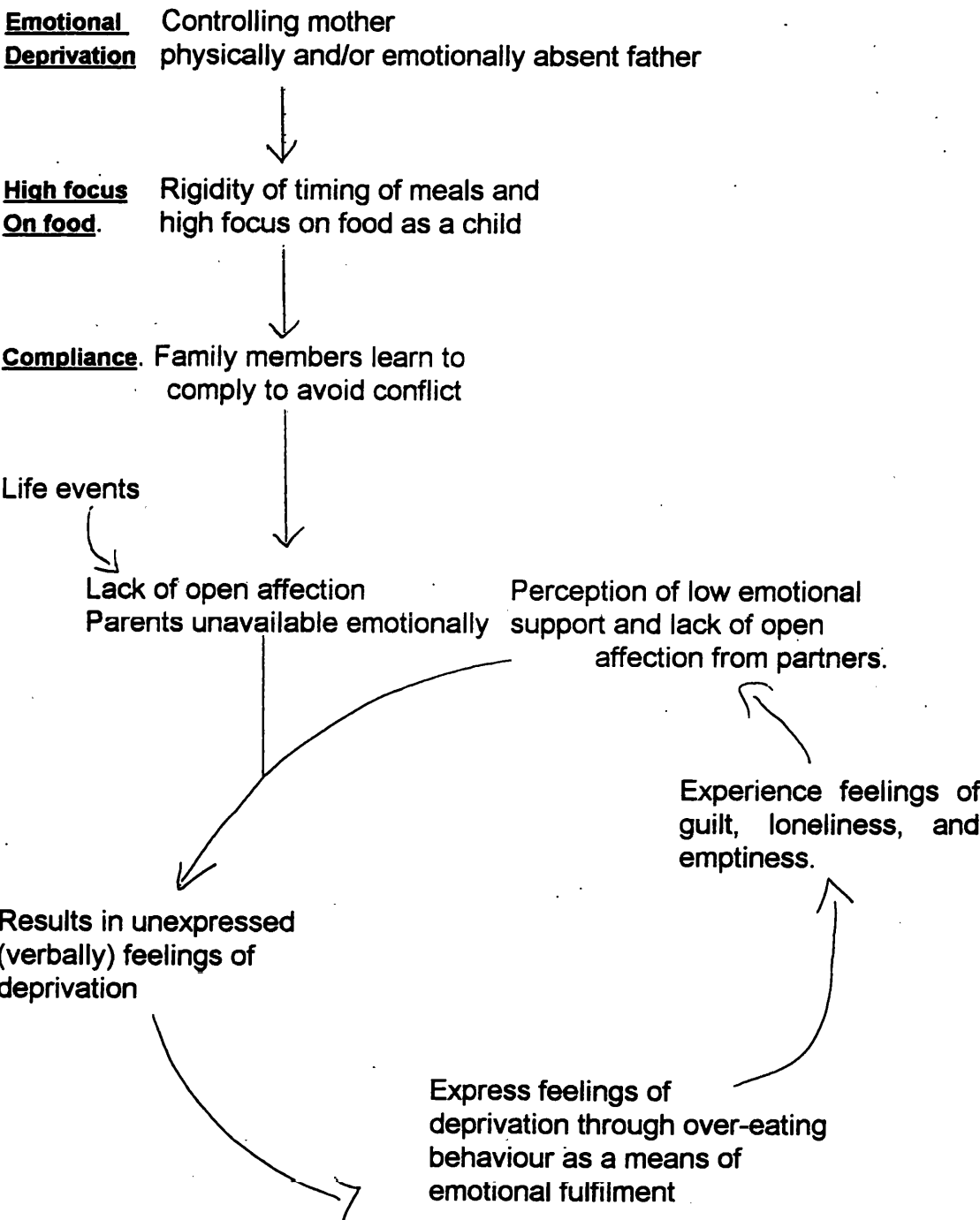
A tentative theoretical framework to explain participants' responses to the interview questions is presented. The theoretical background comes out of the data and emerging themes presented in the results section. The framework fits in with several existing theoretical models representing the women's experience of over-eating perceived through their childhood and ongoing relationships. This suggests that there are several contributing factors. The discussion will present an evaluation of the study's findings and methodological critique. Clinical implications and future recommendations will be presented at the end of the discussion section.

4.2 Emerging theoretical framework

The three superordinate themes of compliance, emotional deprivation and high focus on food are apparent in the process experienced by women who overeat, shown in Figure 1. Although the formulation is provisional it can be understood and to some extent validated and understood in the context of other already existing theoretical models.

The formulation presented in Figure 1 comes from the data, but fits in well with other already existing literature on familial factors in eating disorders, Maines (1993) 'Father Hunger', social learning theory, transgenerational patterns of eating, and psychodynamic theory.

Figure 1: Diagrammatic representation of the processes experienced by women who over-eat.



(i) Conflict Avoidance

The analysis demonstrated that women who experience over-eating perceived their early and ongoing family relationships as avoiding conflict to "keep the peace". Some of the desire to avoid upset came from their relationship with their mothers who were described as 'controlling'. Minuchin et al (1978) also noted the pattern of conflict avoidance and poor conflict resolution when treating anorexics, as two of their four identified primary patterns of psychosomatic pathologies. They viewed the anorexics' eating behaviour as symptomatic of family process. In this study, women avoid expressing conflict for fear of being reprimanded by their controlling mother. They reported not being able to express anger. This fits with Hooker and Convisser (1983) who suggest that women use food to "stuff down" the feeling of unexpressed anger. Similarly, Johnson and Flach (1985) found that bulimics perceived their families as having a great deal of unexpressed anger and conflict, when completing the Family Environment Scale (Moos and Moos, 1980).

(ii) Physically and/or emotionally absent father

The analysis shows that some women perceived their fathers to be either physically and/or emotionally absent through their childhood. Some women attributed their over-eating behaviour to this. Margo Maine's (1993) model of "Father Hunger" describes a framework where conflict is avoided within family relationships and communication is either stunted or minimal. She suggests, as in this study that problems are denied or avoided to "keep the peace". Her belief is that because disagreements cannot be discussed, that children do

not learn to negotiate a position for themselves in the family and hence old roles remain unchallenged. Additionally, she suggests that women who grow up without a positive connection to their fathers suffer considerably from their father's lack of attention, and left unsatisfied, women's 'hunger' for their father (emotional connection) becomes converted into problems with food. This supports the present findings where some women described a lack of emotional availability from their fathers, and the craving for an emotional connection with them in order to feel fulfilled.

(iii) High Focus on Food

The analysis suggests that there is a high focus on food experienced by women through their childhood. Many of the women's comments were about observing their mother's eating pattern of hiding food, rigidity of the timing of meals and rules about food. Tucker and McNamara's (1995) belief that there is a link between daughters' and parental patterns of eating supports these findings. They suggest that daughters learn how their mothers use food emotionally, use dietary restraint and observe their eating attitudes. Social Learning theory (Gleitman 1986) suggests that children learn from behaviour modelled by influential figures (e.g. mothers), and are likely to behave in a similar way themselves at a later date. For example, children may observe that their mother does not express conflict but gains emotional fulfilment through food, engages in secret eating and is rigid around the use and timing of food.

(iv) Lack of open affection

Data from this study indicates the importance of nurturance and open affection to the women of this study. It would appear that they perceive their parents as unavailable emotionally, and not making time to listen to them. Many of the women could not remember openly expressed affection or love from their parents when they were children, and indicated that there was a lack of cuddles from their parents in the present too. The data would suggest that a lack of affection results in emotional deprivation which cannot be expressed for fear of conflict, therefore women seek nurturance and comfort in food. This complements Mills (1994) perspective who suggests that women use food when they need nurturance, love, affection and intimacy, and that it can become a buffer between them and their unfulfilled feelings and needs. Humphrey (1986) has reported that a bulimic and her family repeatedly crave food and attempt to solicit nurturance, soothing and empathy from one another. She suggests that such distressed family relationships are not confined to childhood but persist in the adult bulimic's ongoing relationships with their parents, maintaining the bulimia. This could be a useful framework for interpreting the present data, women who experience over-eating continually seek emotional fulfilment from their parents and the established pattern continues into adulthood. Eating is therefore used as a replacement for other emotional needs. Flodmark (1997) suggests this response is established early in the mother/child relationship if the child's need for love and warmth is not adequately fulfilled.

(v) Emotional support

The results of the study indicate that a lack of emotional support from parents and significant relationships contributes to the ongoing pattern of over-eating. By not having supportive relationships, where women can share their feelings of guilt, loneliness and emotional deprivation, the eating behaviour continues, as a symptom of lack of emotional fulfilment. Wilson (1989) suggests that women who have inadequate social support and ongoing interpersonal difficulties are more likely to relapse into over-eating behaviour. Linked to this is Humphrey's (1986) findings that eating disordered families are less supportive of one another and less expressive of feelings than families from control groups completing the Family Environment Scale (Moos and Moos, 1980).

4.3 Evaluating the Study's findings

Evaluation of the reliability and validity of the study is presented below.

4.3.1 Auditability

By exposing the research process and researcher's interpretations, this study can be "audited" (Miles and Huberman, 1994). By opening up the research process in this way, the reader should be able to make their own interpretations and understanding of the data.

The process of analysis was detailed in the results section. The first stage of the analysis remained close to the data but the latter stages of the analysis, particularly the emerging theoretical framework, relied more on the

researcher's interpretations on the central issues. It is therefore important that the researcher's bias can be evaluated by the reader (Bannister, 1994). This was done by detailing the researcher's assumptions, feelings and interpretations in two ways:

- (1) the literature existing in this field of study, outlined in the introduction, contributed to shaping the research questions, and
- (2) the researcher provided a reflexive account of the research process by recording all ideas and interpretations in a research diary (Appendix 8)

4.3.2 Respondent Validity

The researcher fed back the emerging analysis on all the interviews to the two pilot participants in order to validate the study. Both participants were asked if their own experience reflected the codes and categories generated in the research. Henwood and Pidgeon (1995) question whether this is a suitable method for assessing validity given that participants may not challenge the researcher if they thought them inaccurate. However, the researcher of this study received assurance from the pilot participants that they would challenge the tentative conclusions. In general, the categories did appear to accurately reflect the pilot participant experiences. (Appendix 11).

4.3.3 Inter-Rater Reliability

The categorised text was judged by an independent rater (Appendix 10). The inter-rater reliability was fairly good, with higher agreement on category than code assignment. Considering the codes represent a more 'basic' level of

analysis this could be surprising since the basic codes were less abstracted. However, the independent rater was experienced at qualitative analysis and design.

4.3.4 Generativity

This refers to the extent to which the research facilitates further issues and questions for investigation (Miles and Huberman, 1994). A number of clinical implications and further ideas will be discussed in following sections.

4.3.5 Rhetorical Power

The final way of evaluating this study concerns the rhetorical power of the presented thematic and theoretical analysis (Henwood and Pidgeon, 1995). Supervision was used to review the findings but the reader is invited to reach their own conclusions.

4.4 Methodological and Conceptual Issues

4.4.1 The generalisability of the research findings.

Generally, qualitative research methods do not require the researcher to recruit large number of participants. Silverman (1993) suggests that it aims to develop an in-depth understanding of the individual's process. However, a limited sample impacts the generalisability of the research findings and the level of development of the emerging theory.

First, the sample only contained participants who were known to the Eating Disorder Unit in one district. The researcher chose participants who had therapeutic services available to them in case the subject matter distressed them. However, this only tells us about women who are concerned enough about over-eating to request treatment. This raises the question to whether this had affected the thinking of the participants and whether a different sample (e.g. slimming club) would have yielded the same pattern of results. Since all the women were recruited from the same therapy service, this raises the question whether this district puts more emphasis on providing therapeutic interventions for women who over-eat. In other districts a G.P might simply refer such cases to a dietician.

Secondly, it would be interesting to explore whether men who over-eat experience the same feelings regarding their early and ongoing relationships as women.

Thirdly, because the researcher recruited participants who volunteered, there may have been some self selection bias. This could mean that the three women who did not respond, did not experience their overeating in similar terms to those who responded. Did these women feel stigmatised and intruded upon by the invitation to expose their over-eating behaviour, or did they feel "recovered"?

The researcher relied upon the Eating Disorder Unit to provide participants they defined as over-eaters. However, the researcher became aware that at least one volunteer (data excluded) was bulimic. There was no medical diagnosis and the researcher had to rely on the women themselves to define their eating pattern.

4.4.2 Other limitations of the study.

The lack of the overall time span of the project meant it was not possible to fully implement the grounded theory method to develop the theoretical sampling and to develop and test the emerging theory using analytic induction or deviant case analysis (Strauss and Corbin, 1990).

4.4.3 Ethical Issues

The researcher attempted to ensure that all participants had a therapeutic contact within the Eating Disorder Unit in case the subject matter unsettled them. The researcher suggested that two of the participants share their difficult feelings experienced during the interview, (e.g. one woman became distressed about losing her child in a custody battle) with their therapist or G.P. However, the researcher does not know whether this occurred or not.

4.4.4 Impact of researcher - transference issues

The researcher is aware that during the interviews she was 7/8 months pregnant and impending motherhood was obviously on its way! She is aware that many of the participants spoke of her pregnancy with interest. It is interesting to reflect on the powerful impact that this may have had on some

women, who were being asked to think about their own early experiences and their one-to-one relationships with their mothers. Did this steer them into thinking about the way in which they were parented, nurtured, or loved? It is possible that the researcher's pregnancy may have affected the degree of openness and freedom with which the women were able to discuss difficult relationships with their mothers. Is it possible that the desire to nurture another may have been elicited?

4.4.5 Implications for Clinical Practice and Service Delivery

The research results suggest several important therapeutic implications for women who experience overeating.

(a) Systemic Interventions

Therapeutic interventions which only consider changing the way women think about their eating pattern or looking behaviourally at recording their intake of calories is arguably not going to address the issue of causality or maintaining factors, and could continue to be stigmatising to women. Intervention that considers a systemic framework that takes into account family relationships, both early and present patterns of communication, will reframe women's over-eating pattern as a symptom of the family process, rather than a problem that is inherent in the individual woman. This may also help women feel more supported by professional groups such as G.Ps, dieticians and therapists. It would be interesting to explore whether using a systemic framework to understand these women's problems and thereby offering family therapy or individual systemic work would increase the success of intervention. This is

supported by the evidence discussed earlier that systemic interventions are more effective in the treatment of anorexics (Russell et al, 1992) and bulimics (Dodge et al, (1994) than those offered individual therapy.

At present results of CBT and group work are inconsistent. However, it is important to consider whether failure of some current therapy may be partly or wholly due to the failure of the implementation or insufficient training of nurses or others working with over-eaters.

The analysis from the present study indicated that a proportion of the women in the sample experienced their fathers as being emotionally unavailable. Future research needs to test for its generalisability across over-eaters. If it is a general pattern then a structural family therapy approach may be able to help fathers become more emotionally expressive and more actively involved, by realigning the subsystems and helping the parental subsystem to function more appropriately. If women are being seen individually, using systemic methods to re-connect women to their fathers may help women to understand the impact of this absence on each family member and explore different ways of managing their feelings.

Former research has indicated that mothers whose daughters develop disturbed eating attitudes and behaviours have their own disturbances in object relations, specifically insecurity in attachments, making these mothers more sensitive to rejection and becoming easily hurt (Tucker and McNamara, 1995). This could inform clinicians about the potential issues mothers may

have and thus allow more sensitivity in working with them. It may also help mothers to understanding how their issues may bring about their daughters compliant relationship with her.

Additionally, early family intervention for children who over-eat could address the trans-generational meanings of food and eating, and the problematic family dynamics before a perpetual cycle of bingeing and feelings of guilt and loneliness take hold. Flodmark (1997) proposes that systemic intervention before the age of 10 years can reduce the progression of obesity in later teenage and adult years.

Graber and Brooks-Gunn (1997) advocate intervention that targets the eating attitudes and behaviours of parents along with their daughters. With this in mind, a systemic intervention that includes and educates parents and children in how parental eating patterns can be learnt may prevent exclusive focus on the child as the source of the problem.

b) Support.

The results also suggest that women who over-eat experience a lack of support from significant relationships. Therefore, part of an intervention offered should make a thorough assessment of the amount of support perceived by women, and if inadequate, ways which increase support should be put into place. Many of the women in this study felt that telephone help-lines could be useful. In addition, most felt that emotional support from family and partners would be beneficial. It is important that therapists look at the

ways in which women elicit support as well as partner's and others' attitudes because inadequate social support and interpersonal difficulties have a considerable impact on increasing relapse in over-eating behaviour (Wilson, 1996).

Additionally, some women spoke of feeling "dropped" by the healthcare systems after the scheduled number of sessions and then left to cope with their eating pattern again. This could be perceived as a lack of support from the system which would parallel the lack of support they have perceived in their early and ongoing relationships. Although there are mixed reports on the effectiveness of booster sessions in the treatment of obesity, Perri et al (1984) did find some success. Therefore, the possibility of booster sessions may help women to keep focused on changing their eating pattern, feel supported, and help prevent the loneliness they describe feeling.

c) Education

G.Ps would need to be educated that in cases such as these, psychological rather than physical interventions may be required. They would also need to understand how to filter such women into the correct services.

4.4.6. Recommendations for Future Research

(a) Testing out the emerging theoretical framework

It would be interesting to test the emerging theoretical framework by carrying out a series of single case designs by obtaining a clinical sample of either

children or women who experienced over-eating. It may be interesting to explore a sample of bulimics and anorexics to delineate defining factors for over-eating compared with these other disorders. Additionally, a sample of women who have the early family factors found here, but who are not over-eaters may be helpful in testing out the emerging theoretical framework.

Additionally, a comparative study of two groups of women who experience over-eating would be a useful way of seeing whether a systemic intervention would be more effective than CBT or groupwork, which is presently offered to women who experience over-eating. It would be interesting to see if treatment programmes that focused on family closeness, flexibility of family rules, spousal communication, and ways of dealing with anger and other difficult emotions could be helpful in achieving and maintaining weight reduction. This could be a similar systemic model of obesity to the one proposed by Ganley (1986) with an emphasis on family dynamics and understanding the eating problems within the interpersonal context, rather than on controlling the eating behaviour *per se*. Results of such a study would need to be followed up both short and long term to identify the rates of relapse, which are evident and problematic for this group of women (Wilson, 1996). If successful, an intervention which is effective and less stigmatising for women, and reduces relapse, would be cost effective, especially if they were developed in already existing systemic clinics.

b) Continual evaluation of the study's findings

Respondent validity will be evaluated by sending a summary of the emerging themes to the participants. They will be asked to comment and provide feedback on how they see the accuracy of the study's findings. Additionally, the researcher will contact professional groups and will share her emerging theoretical framework. In this way, rhetorical power can be further examined.

c) Further research in this field

Other research questions have arisen from this research. For example, would men who experience over-eating, perceive similar early and ongoing family relationship patterns as women do? Why is it that more women experience difficulties with over-eating than men? (White, 1992). If the families of children who over-eat could be offered systemic intervention, would their need to communicate unexpressed feelings through the use of food change to verbal communication? If this happened and could be measured, would their eating pattern change? Why is it significant for some women that fathers are absent physically and/or emotionally, but not for others? What components of this model are exclusive to over-eaters, compared with for example, other eating disorders and other problems with important psychological dimensions? Does the relationship between women experiencing over-eating and their partners echo the process between women and their family relationships? If so, does this contribute to their over-eating behaviour continuing? If these research questions could be answered, the needs of women who experience over-eating may be more fully addressed.

Conclusion.

Generally there is much interest in eating disorders concerning bulimia and anorexia, however there is relatively little literature on over-eating behaviour. There has been some interest with obesity but this has mostly been concerned with relapse prevention and treatment methods. This previous research fails to consider the emotional component of eating and other possible developmental and maintaining factors such as quality of relationships.

This study provides a new perspective on women who define themselves as over-eaters. With the use of grounded theory it aimed to gain a greater understanding of what women believe contributed to their eating behaviour and whether early and ongoing family relationships, other significant relationships, and level of perceived support contribute to their over-eating behaviour. Although only tentative conclusions can be made from the theoretical framework which has developed from participants' responses to the research questions, it would appear that clinical psychologists, working systemically, may have much to offer women and their families with this problem. The emergent tentative model fitted in well with existing literature on contributing factors to adjacent disorders (bulimia, anorexia) and with studies on obesity.

Further research must be carried out to specify more discriminatively, and expand the framework developed. Additionally, comparison studies of systemic versus CBT or group work should be carried out, both with short and long term outcome measures to analyse clinical effectiveness of interventions indicated by the model in comparison to existing treatments. However tentative the conclusions, the theory has several important implications for clinical practice which may readdress some of the stigma and loneliness women who over-eat experience, both from the public and professionals. -

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Appendix 1

Semi-structured interview: Outline of themes, questions and prompts.

Demographic information sheet:

What type of therapy and duration of contact have you had with the EDU?

1. How do you like to be addressed?

2. What is your age?

3. Do you have a partner at present?

4. Do you live with your partner?

If no, do you live with anyone else?

5. How long have you been in this present relationship?

6. Do you have paid work at present?

Is this full time or part time?

What sort of work do you do?

If not, how do you spend your time?

7. Do you have any children?

How many?

How old are they?

8. Did you grow up with your natural parents?

9. Do you have brothers and/or sisters?

How many?

Are they older or younger than you?

Theme 1- Family relationship patterns as an adult.

1. Do you have regular contact with your parents or those you regard as your parents at the moment?

How often?

Where do you tend to see them?

How do you feel about how often you see your parents?

Is it too often? Just right? Too little?

Can you tell me more about that?

2. How do you feel about your relationship with your parents?

3. Do you feel that family members support each other?

Your parents? Your partner? Your siblings?

How do they show their support?

4. Do you feel that you can say anything you want to at your parental home?

In your own home?

Where would you say you're mostly 'yourself' ? How is this different from how you feel at other places?

5. How do family members deal with their anger?

Who?

When?

6. Can you tell each other about personal problems?

Parents? Partner?

7. How openly can family members express criticism of each other? Parents?

Partner?

When?

Who does?

Why?

Has this always been the pattern?

8. How do family members show their affection/love for each other?

Who does?

When?

How often?

Who is usually the first to offer affection?

How do family members respond?

Has this always been the pattern?

Theme 2- Family interactions around food and meal times as a child

1. Who usually prepared the meals in the family?

Did this change?

2. Did you eat with the family?

How often?

Where?

3. Can you tell me what childhood memories you have of meal times?

Can you remember any specific conversations you had at meal times with your parents or those you regard as your parents?

Can you remember how you felt then?

4. Were there any times when arguments happened at meal times?

Can you tell more about that?

Was this typical or not?

Who were the arguments between?

How were you feeling at these times?

How did you deal with that?

5. What other childhood memories do you have of eating (not specifically related to meal times)? Example?

Was food ever used as a punishment/reward?

6. Can you tell me anything about your families eating patterns that you think may be relevant to your own eating pattern.

Theme 3-Over eating behaviour.

1. When did you first feel that your over eating became a concern in your own mind?

For your parents? Others?

2. Can you remember how you felt about food or eating when you were a child?

At home?

At school?

Other environment?

Pregnant?

3. As a child, thinking back to the beginning of your eating pattern, what do you feel was the cause at that time?

Do you remember any specific examples?

Can you tell me more about that?

4. As an adult, what do you think keeps your eating pattern going?

5. How do you feel before you eat?
During eating?
After you've eaten?
6. Who prepares the food in your home?
Has this changed?
7. Do you eat as a family?
How often?
Where? When?
8. Are there times when you notice your over eating behaviour is better?
Worse?
What is happening at these times?
Is anyone else involved? Who?
How does it make you feel?
9. Has your over eating pattern remained the same over the years?
Can you think of a time when it has been different, even slightly?
10. When the topic of food comes up, how do you feel?
How do you deal with this?
How have you felt answering my questions today?
If you were to remember anything from this interview today, what do you think you might be thinking about?
11. Anything you feel I haven't asked you?

Prompts to be used during the interview:

Who? When? Where? What? How? How much? Why?

Appendix 2

Dear Mrs. New,

EXPLORING PERCEIVED EARLY FAMILY RELATIONSHIPS AND CURRENT RELATIONSHIP PATTERNS IN ADULT WOMEN EXPERIENCING OVER EATING: A QUALITATIVE STUDY

PROTOCOL NO. 60/97 (Please quote in all correspondence)

Thank you for submitting the above named study to the Tunbridge Wells Local Research Ethics Committee who reviewed it, together with the protocol, Patient Information Sheet and Consent form, at their meeting on Friday 21st November 1997.

The members of the Committee present agreed that there is no objection on ethical grounds to the proposed study whose title is given at the head of this letter. I am therefore happy to give you our approval on the understanding that you will follow the protocol as agreed.

It is your responsibility as the researcher who made the application to notify the Local Research Ethics Committee immediately you become aware of any information which could cast doubt upon the conduct, safety or an unintended outcome of the study for which approval was given.

If there are amendments which, in your opinion or opinion of your colleagues, could alter radically the nature of the study for which approval was originally given, a revised protocol should be submitted to the Committee.

You will no doubt realise that whilst the Committee has given approval for the study on ethical grounds, it is still necessary for you to obtain approval from the relevant Clinical Directors or Chief Executive of the Trust in which the work will be done.

Members of the Committee would like to know the outcome of the study and therefore ask that a report or copy of results is sent to the Secretary in due course.

Yours sincerely,

CHAIRMAN

LOCAL RESEARCH ETHICS COMMITTEE

Appendix 3

Elizabeth New
Clinical Psychology Postgraduate Department
Salomons Centre
David Salomons Estate
Broomhill Road
Southborough
Tunbridge Wells
Kent TN3 0TG

16 January 1998

Dear Ms New

I am writing further to your recent correspondence concerning the research you wish to carry out at our Eating Disorders Unit in Oakapple Lane. I am now writing to confirm that you have our approval to carry out your project which sounds very interesting. We would be pleased if you would share your findings with us on completion of your work.

I trust this meets with your satisfaction.

Yours sincerely

Chief Executive

cc:

Appendix 4

Salomons Centre
David Salomons Estate
Broomhill Road, Southborough
TUNBRIDGE WELLS
Kent TN3 0TG

Telephone: 01892 515152
Facsimile: 01892 539102



**SALOMONS
CENTRE**

Participant Information Sheet

Study: Exploring early family relationships and current relationship patterns in women experiencing over eating.

Interviewer: Elizabeth New, Clinical Psychologist in Training.

This study is interested in understanding how family relationships in childhood and adulthood may be linked with eating behaviour in women. There has been much research written about women learning their eating behaviour through family members and about genetic causes, but very little on what women experiencing over eating feel the cause is themselves.

This study is entirely voluntary and would take the form of one interview with the interviewer above. All information gathered would be confidential and all identities will be protected. The interviewer will not publish any results from which the individual may be identified, without seeking participants' consent. The participant has the right to withdraw from the study at any time.

This study is separate from the Eating Disorder Unit and will not influence your treatment in any way. Additionally, information gathered through interview will not be discussed with the eating disorder unit team.

It is hoped that this study will begin to shift public and professional views from blaming women who over eat to understanding the emotional part of this behaviour. It is also hoped that more effective treatment could become available if more is understood from the women concerned.

If you are interested in participating in this study, then please complete the slip below and send it in the stamped addressed envelope provided. If you decide to take part in the study, the interviewer will be in contact with you to organise an interview date.

If you would like more information on this study before deciding whether to participate, then do not hesitate to contact the interviewer on the number above.

Thank you for your time,

Yours sincerely

Elizabeth New

Clinical Psychologist in Training

Name: _____

Address: _____

Telephone number: _____

I would like to take part in the study exploring early family and current relationship patterns in women who over eat.

Signed _____

101

Appendix 5

Dear Mrs.

Our Service has been approached by Elizabeth New, Clinical Psychologist in training, from the Salomons Centre, who is undertaking a study entitled "Exploring early family relationships and current relationship patterns in women experiencing over eating", and we are enquiring as to whether you would be interested in taking part. (An explanatory letter is enclosed.)

It is anticipated that an interview would take place, lasting approximately 1½ to 2 hours. You would be advised of the location, which would be as convenient as possible for you.

This study is totally separate from the Eating Disorders Service and any information given would not be discussed or disclosed to anyone other than the interviewer.

Thank you for your co-operation.

A self-addressed envelope is enclosed.

Yours sincerely,

Encls.

Appendix 6

Participant Consent Form

To be completed by all participants who fulfil the eligibility criteria

TITLE OF STUDY:

Exploring perceived early family relationships and current relationship patterns in adult women experiencing over eating.

Investigator: Mrs Elizabeth New

Please tick box as necessary

	Yes	No
Have you read the participant information sheet ?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had the opportunity to ask questions and discuss the study?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you received satisfactory answers to your questions?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you received enough information about this study?.....	<input type="checkbox"/>	<input type="checkbox"/>

Who has explained this study to you? Dr/Mr/Mrs

Do you understand that you are free to withdraw from this study:

At any time

Without having to give a reason for withdrawing

Without affecting your future medical care..... ☐ ☐

Do you agree to take part in this study? ☐ ☐

Are there any comments you wish to make?.....

Do you consent to your interview being tape recorded?..... ☐ ☐

Signed..... Date.....

Name (in block letters).....

Appendix 7

Appendix 7

Worked example of a coding sequence.

The following piece of extract is from an interview with one of the women in the study. The bold brackets demonstrate the coding process. Subsequently, categories were formed and the themes identified following analysis.

J: On a Sunday, which is the only time my father was there, **[Code: physically absent father]** mealtimes were geared up for being a set particular way, **[code: specific rigidity /routine of food]** so there was no way a family row **[code: absence of family row]**. But (sibling) and I, I think you'd have to know my father a bit, he's a very intimidating man **[code: fear of father]**, if (sibling) and I had a grievance, there is no way we would have expressed it anywhere near my father because we were far too scared of him **[code: avoiding conflict with father, fearful of reprimand from father]**. If I was angry with mum about something, that would not have been aired at all **[code: conflict avoidance with mother]**, we did anything to keep the peace **[code: compliant relationship with mother]**.

Data Management

1. Coding

The data was divided into units of meaning. This involved labelling meaningful units, to enable identification and account for relevant features (column 1).

Codes identified

1. Physically absent father
2. Specific rigidity/routine of food.
3. Absence of family row.
4. Fear of father.
5. Avoiding conflict with father, fearful of reprimand from father.
6. Conflict avoidance with mother.
7. Compliant relationship with mother.

2. Categorisation

Basic codes are compared and grouped together under more general headings by their characteristic similarities (column 2).

3. Thematic analysis

After examining the emergent categories, looking for links and connections between the categories, the themes were identified (column 3).

<u>(Column 1.)</u>	<u>(Column 2.)</u>	<u>(Column 3.)</u>
1. Father physically absent.	Parents physically absent for periods of time.	Parents physically absent.
2. Specific rigidity/routine of food.	Women experienced rules at mealtimes	High focus on food within the family environment
3. Absent family row.	Conflict avoidance	Perceived powerlessness from parental relationship.
4. Fear of father.	Not emotionally approachable.	Emotional deprivation.
5. Avoiding conflict with father, fear of reprimand from father.	Conflict avoidance.	Perceived powerlessness from parental relationship.
6. Conflict avoidance with mother.	Conflict avoidance	▪
7. Compliant relationship with mother	Relationship to parent was of a compliant nature	▪

Appendix 8

Appendix 8

Research diary

9.10.1997

Today I carried out a presentation of my research proposal for nine members of the group and two staff. It was a really useful. Up to now I have felt quite confused with what I'm hoping to find out, but it helped me to clarify my interest. I've been interested in why women experience over-eating for some time, mostly through a personal friend who has been seen by her G.P, dietician and received individual cognitive behavioural therapy (CBT). However, she still has her eating pattern and speaks of emotional trauma from her early childhood relationships. I wonder why anorexia and bulimia appear to gain psychological interest but over-eating doesn't? There seems to be literature on the multi-factorial perspectives, including biological and environmental causes, but very little on the emotional components.

5.11.97

I cannot believe how much work, thought and photocopying it has taken to obtain ethical approval. I do hope my design gets through without too many alterations.

17.11.1997

I spoke to Rudi Dallos (on- site supervisor) who encouraged me to contact [redacted] from the Eating Disorder Unit (EDU) for potential participants. It feels very important to make sure the women I interview have a therapist or worker to contact if the subject matter stir up any emotional upset.

3.12.1997.

I received a letter this morning from the Ethics Committee. They have approved my research proposal, so there is no objection on ethical grounds to my proposed study. What a relief! Now I can get going with arranging interviews and contacting the EDU at

7. 1.1998

I met with . . . , the manager of the EDU at . . . today. We spent some time discussing my research proposal and whether or not there would be suitable participants within the Eating Disorder Unit who had either received help, were currently having help or were awaiting sessions from the Eating Disorder Unit staff. . . . surprised me by saying that she felt that there would be no difficulty finding participants. She could offer me a list of at least 20 participants.

16. 1.1998

I received a list of potential participants from the Eating Disorder Unit today. There are 16 names on the list. The Unit have written on my behalf explaining the research and I will now sit back and hope that I get some responses. 16 are below the number that I originally hoped for. I suppose my feeling is that I might only get a quarter return, so I might have to seek participants from other sources. I saw Sue (supervisor) today and she says if the response rate is very low then I could carry out a qualitative research with 5 as a very minimum. I do hope that I get more participants than that.

21. 1.1998

Today I did my first pilot with an acquaintance and used my semi-structured interview for the first time. The interview lasted about an hour and a half, and I have to say I felt exhausted at the end of it. Fortunately all the technical instruments I was using worked well, which is one thing that usually concerns me. She said some very constructive comments about my semi-structured interview and I was able to add particular questions on the end. In

her feedback she said that it had been the first time that some of the systemic questions had been asked and that she had felt for a long time that family issues were really pertinent to her overeating difficulty, and yet nobody had really sought the history of her family dynamics (she had been in both individual and group therapy). She also fed back that she was not exhausted at the end of the interview !

28. 1.1998

I did my second pilot interview. This was even longer than the first. It went on approximately two hours and I felt very tired listening to so much content within that time. The semi-structured interview seemed to draw upon so much information and I really need to sit down and listen to the interviews again to clarify what my research questions are and whether I am asking for too much content or not. However, I really did get the feeling that my second pilot participant really wanted to unburden herself with the content of the questions asked. I am relieved that both my pilot participants are presently in therapy so that if any distress was brought up in the pilot interviews that they have somewhere that they can take their concerns. This afternoon I faxed my draft of my methodology off to Sue and although there are gaps in it and there is more to do, I feel really positive that I have started to get things down on paper. I still hope that I am going to hear from potential real participants to begin my interviewing.

29. 1.1998

I went into Salomons today and to my delight there were several self-addressed envelopes to me from potential participants. I got four positive replies today, so I am going to ring them as soon as I can and try and make a time to start interviewing.

11. 2.1998

I carried out my first interview today. The interview was shorter than my pilot sessions. I took about an hour and fifteen minutes and to my surprise I was not as tired as I had been

with my pilots. However, what I did feel was some degree of sadness and I wondered whether she was in touch with memories which had lay dormant for some time. The woman was very low in mood and I discussed with her at the end of the session about the opportunity for her to take any issues left from the interview to her psychotherapist. I think my sadness was very connected to the lack of nurturance that I felt she received from her mother and the lack of loving and affection. The word that kept turning over in my mind was "deprivation", and there just seemed to be no sense that her mother was able to give her what she needed. I also wondered about the fact that I am so obviously pregnant and whether this made a difference to the way that this woman responded to my questions. Was she thinking about the mothering that she got when she was a child? I was left feeling that this woman was very lonely and very empty. I wondered whether I felt this because of the contrast of myself – carrying another being (having company) and feeling (and looking) full up.

At the end of the interview she described a memory that she had as a child; that when she was caught smoking in a convent school the whole family, her sister and her father and her mother were called up to the convent school for a family meeting. She said that she felt that was the most significant and constructive time her family were ever together, how a real 'open' conversation was present just for the 20 minutes. She said she would advocate more family meetings as a way forward for her, to begin to express the needs that she does not feel have been fulfilled. This reconfirmed my interest about how women perceive their early and ongoing family relationships. It made me feel that my study will have important clinical implications.

13. 2.98

I got to Salomons today and I had another three replies from participants. I am beginning to believe that I will have a large enough sample to carry out my design. Now I just need to make sure that I have got time to complete the interviews before I go off on maternity leave.

19. 2.98

I travelled to to interview a women today. I was about three quarters of the way through the interview when I realised the participant did not fit my criteria. She began to tell me that she binged regularly and made herself sick, very much under the criteria of a bulimic. This has thrown up questions in my mind about how my participants were selected through the EDU. I was deeply concerned about this particular woman. She was incredibly low in mood and was bingeing and purging on a regular basis and although she had received help through the Eating Disorder Unit in the past, she was not gaining any help or support from any professionals at this time. She also was in a particularly difficult family environment. I urged this woman to go back to her G.P. and to get him to re-refer her to the Eating Disorder Unit. I could not use her material in my research but, I suppose, that I hoped that she would seek help after the interview had finished.

23. 2.1998

I have now heard from thirteen participants who have been interested in carrying out the research. I have got three interviews to carry out this week and although tired it seems to be going well and I am adjusting my semi-structured interview as I go. The interviews seem to be a little swifter and I am enjoying the flexibility that qualitative research allows. I am being much more spontaneous with my prompts and questions. I have been so amazed that I received 13 replies out of 16. I wonder why there has been such a good response? I have decided I will ask the women during the rest of my interviews.

4. 3.1998

I have finished off my interviews today - I did three, and it was an incredibly tiring day but I now have got twelve interviews that I can use for my research. Whether the information will answer my research questions or not, there appears to be a worth of interesting material in an area that has had little psychological attention to it

11. 3.1998

I have begun to transcribe the interviews and am feeling quite a strong reaction to some the content. I wonder whether the intervention being offered to women who experience over-eating is always appropriate for them? Whether somehow the professional system is echoing the family process of emotional deprivation, that they are offered a few sessions of group or individual work and then they have a sense of being dropped (deprived) by the professionals?

I really cannot believe how long it has taken me to transcribe one tape and I am left with an interview which is full of content and twenty four pages of A4. My hopes have always been that I will be able to give my dissertation in July like everybody else. I feel as though I have been steadily working and have been on schedule all the way through. I have finished my interviews and am beginning to transcribe the data. However, my baby is due in 5 weeks, and I wonder whether I will be able to continue to study.

20. 3.1998

I feel that reading the contents of the transcribed interviews is really making me think about being a mother myself. The content of the interviews is incredibly moving and at times very sad and I am left wondering about what a difficult job it is to be a mother, and how difficult it appears to be able to fulfil the needs of your child completely.

31. 3.1998

The last interview has been transcribed and I am now left with a huge job in front of me of beginning to read and re-read the content of the transcripts. I am beginning to feel incredibly heavy with my pregnancy and quite irritable. I feel I need to rest, to think about my baby coming into the world, and give myself the headspace to welcome him.

27. 5.1998

Harry (my son) arrived a week early on the 16 April and I have been quite pre-occupied with loving him. I went in to see Sue at Salomons and to discuss how I felt with my dissertation. I

have serious doubts now in my mind as to whether I will be able to complete the dissertation for the July deadline. I do not want to give up and feel ambivalent about letting it go. Sue was extremely helpful, very focused and very flexible about it. I have decided to do little bits of it and see where I am in a couple of weeks.

17. 7.1998

I have missed the dissertation deadline and realise now, even with an extension that I could not have completed it. So with much regret I will put my dissertation down and begin again when I go back to Salomons in September, and enjoy the rest of my maternity leave.

11. 9.1998

I had a meeting with Sue today and I scheduled a new work timetable to finish off my dissertation. We talked in detail about beginning to code and categorise the content of my interviews. I realise that I need to begin again to re-read the women's stories.

18. 9.1998

I am finding it really hard to focus back into the dissertation. Reading the transcripts, there appears to be an underlying feeling of deprivation from the women's mothers and fathers. It makes me feel a great sadness when I read these women's accounts of the lack of nurturance, comfort and availability they received from their parents. It appears that we as professionals mirror this process with our lack of interest in women's experience of over-eating.

13.10.1998

I met Sue today and we talked about the beginnings of my basic codes and how to devise rating forms for my inter-rater reliability study. I realise I have got so much work to do and I am making very, very small steps in progress towards completing my dissertation. Whereas last year I seemed to be able to throw myself into it with enthusiasm and interest, I am beginning to worry that it is going to take much longer than I had originally hoped.

30.11.1998

I met Sue again at Salomons. We discussed my themes and my ideas of the theoretical framework which may fit the data. The underlining theme that is coming through seems to be a great amount of emotional deprivation for the women. I am beginning to feel excited again about coming to the end of my analysis which just seems to have been hanging over me for the last six months. I am hoping that my write up will come much more easily and freely.

6. 1.1999

I have heard from my rater that they have finished the inter-rater reliability study, so hopefully now I can make headway with finishing the analysis and start to write up.

8.3.99

I have given Sue a final draft and await feedback.

15.3.99

Feedback from Sue was constructive and encouraging. I'm nearly there.....

Appendix 9

Appendix 9

Categorisation of basic codes into conceptual codes.

1. Participant's perception of their early parenting (Number of participants in brackets)

1. Mother was controlling (8)

Manipulative relationship (5)

Verbal discipline (5)

Physical discipline (2)

2. Relationship to parent was of a compliant nature (10)

To avoid conflict/ upset (10)

3. Parents physically absent for periods of time (9)

Father worked abroad (1)

Child sent away when sibling born (1)

Father physically absent (2)

Father worked late regularly (5)

4. Father physically absent at mealtimes (9)

5. Parents were unavailable emotionally. (9)

No relationship with father (5)

Not emotionally approachable (2)

Never listened to women (5)

Life event prevented emotional contact (1)

Lack of physical contact (8)

6. Women were cautious to share personal material with parents (5).

To avoid conflict (5)

Women perceived parents were unavailable to listen (4)

7. Women could not remember love and affection from parents (8)

Lack of physical affection from mother (6)

Lack of physical affection from father (8)

Never felt loved by mother (2)

Materialistic affection through presents (3)

Father had affair (2)

8. Women experienced rules at mealtimes (8)

Specific rigidity /routine of food (6)

Specific mealtime rules, e.g. 'clear your plate' (7)

9. Women experienced parents dictating food intake (5)

Diets (2)

Extra food given between meals (3)

To eat what was given (4)

Food used as a punishment (3)

Food used as a reward (3)

10. Women felt deprived of food (9)

Women felt hungry in childhood (2)

Food portions were restricted by mother or father (6)

Father had specific foods, e.g. given steak (1).

11. Women experienced secret eating (9)

Hide food in planned way, without parental knowledge (6)

Hide food in unplanned way (3)

12. Generational patterns of eating observed (6)

Father or mother diabetic (2)

Observed mother secret eating pattern (4)

Certain week day patterns, e.g. "Thursday was baking day".

Mother or father were over- eaters (5)

2. Women's perceptions of ongoing relationships with their parents.

1. Women experienced their mother as controlling (8)

Manipulative relationship (7)

Verbally demanding (8)

2. Compliant relationship with mother (5)

To avoid conflict (5), e.g. 'to keep the peace'.

3. Avoiding conflict with parents (9)

Due to reprimand from parents (6)

To avoid mother being upset (5)

4. Women feel rejected by their father (9)

Women feel unimportant to father (5)

Women feel an inconvenience to father (3)

Father rejected their affection (4)

Father criticised their decisions (2)

5. Absent affection from parents (7)

Absent physical affection (6)

Absent verbal affection (7)

6. Father emotionally unavailable (5)

Lack of emotional relationship with father, e.g. 'no one to one contact' (5)

'No time to listen to me' (5)

7. Absent support from parents (10)

8. Skewed perception of women's maturation from father (2)
e.g. 'Treats me like a child' (2)

3. Participant's views on level of support from significant relationships (other than family).

1. Partner supports women domestically (4)
e.g. with house or child issues (4)

2. Partner supports women emotionally (3)
e.g. 'He never criticises me or complains'

3. Partner supports women financially (3)
'He pays for things'(3)

4. Partner does not show love or affection (6)
No physical affection (2)
Lack of verbal affection (5)

5. Partner does not support women emotionally (6)
Women feel misunderstood by partners (5)
Partner complains about their weight (4)
Arguments (4)

6. Partner does not show anger (5)
Avoids conflict (5)

4. Participant's views on their relationship with food

1. Memories of food at school (11)
Food used as a punishment (5)
School dinner rules (negative) (3)
Enjoyment/privilege position of dinner monitor (1)
Deprivation (2)
Teased (2)

2. Secret eating (10)
Ate to relieve emotional feelings (10)

3. Cause of over-eating due to relationship with mother (5)
Difficult relationship e.g. controlling mother, compliant relationship(5)
Mother put me on a diet (1)

Rejection from mother (1)

Lack of attention (2)

4. Cause of over-eating due to relationship with father (3)

Lack of affection (3)

Lack of attention (3)

Difficult relationship with father (3)

5. Cause of over-eating due to life event (2)

Sexual abuse (1)

Siblings death (1)

6. Cause of over-eating due to emotional (internal) feeling (8)

Guilt (5)

Loneliness (5)

Escape (2)

Emptiness (4)

Angry (2)

Upset (6)

7. Continue to over-eat due to external cause (3)

If alone (2)

Due to large portions (1)

Appendix 10

Inter-Rater Reliability

Instructions for Rater

- 1) The aim of inter-rater reliability is to determine to what extent an independent rater concurs with the codes and categories I have generated from the responses given by participants to the research questions. I have provided you with extracts of two interviews chosen at random. I have also enclosed two rating scales (with two copies of each).
- 2) To start with I would like you to use the 'category' rating scale. I would like you to read through the two interview extracts carefully. As you read through them I would like you to think about the following four research questions:
 1. How do participant's perceive their early parenting?
 2. How do participant's perceive their ongoing relationship with their parents?
 3. How do women perceive support from significant relationships (other than parent)?
 4. How women perceive their relationship with food?
- 3) After reading both interview extracts I would like you to take one of the extracts and one of the 'category' rating scales. Put the participants number at the top of the rating sheet. I would like to read the interview extract again, this time ticking one or more of the category boxes whenever you feel a participant has made a comment that fits it. Please only tick a box once, however many times they comment on that category.
- 4) Please complete this procedure for both interview extracts, using a new rating scale for both.
- 5) Could you then take the 'codes' rating scale. Please repeat the procedure, this time ticking off boxes on the 'coding' rating scale.
- 6) If there were any comments in the interview extracts that I have not coded or categorised which you feel are relevant to my research questions, would you give a brief summary at the bottom of the rating scale.

Thank you for your help.

Definitions

Compliant

Women try to please their parents by doing as they are asked, to keep the family environment free from conflict.

Love/affection

The showing of love either verbally, e.g. 'I love you' or non-verbally, e.g. cuddles, kissing.

Deprived

A woman feeling that something is lacking in their lives.

Secret eating

Consuming food without the awareness of any one else.

Conflict avoidance

Avoiding upset or arguments with other family members. Attempting to keep relationships calm and steady.

Unemotional

Not showing signs of internal feelings overtly.

Emotionally Absent

Not able to support women in emotional ways, e.g. when women need to express their concerns, other family members do not listen/give them time.

Anger

Verbal or physical means of showing aggression. Verbal example – shouting, swearing.

Physical example – punching, hitting.

Feeling empty

Emotionally feeling unfulfilled/unsatisfied.

Physically feeling hungry.

CODING RATING SCALE

Participant Number:-

Q1: How do participants perceive their early parenting?

- | | |
|--|-----|
| Felt that their mother was domineering/controlling | [] |
| That they experience a compliant relationship with their parents | [] |
| That their parents were emotionally and/or physically absent | [] |
| That they sought recognition from their parents | [] |
| That their parents avoided conflict | [] |
| That parents did not show anger | [] |
| That they were cautious to talk openly to their parents | [] |
| That their parents showed them love/affection | [] |
| That they felt deprived of love/affection | [] |
| That their father was physically absent at most mealtimes | [] |
| That they felt deprived of food | [] |
| That they stole food/experienced secret eating | [] |
| That food was used as a punishment | [] |
| That food was used as a reward | [] |

Q2: How do participants perceive ongoing relationships with their parents?

- | | |
|---|-----|
| They experience their mother as domineering/controlling | [] |
| Experience a compliant relationship | [] |
| Conflict avoidance | [] |
| Father as unemotional | [] |

Q2 continued

- | | |
|----------------------------------|-----|
| Their parents as unsupportive | [] |
| Their parents as supportive | [] |
| Emotionally absent | [] |
| No physical contact between them | [] |

Q3: Are females who continue to Over Eat in adulthood perceiving insufficient support from signification relationships (other than parents)?

- | | |
|--|-----|
| Absent relationship with siblings | [] |
| Lack of support from partners | [] |
| Support from partners | [] |
| Partner avoids showing anger | [] |
| Reduced sexual relationship with partner | [] |
| Partners show love/affection | [] |

Q4: How females perceive their relationship with food:

- | | |
|---|-----|
| Feeling deprived at school | [] |
| Food being used as a punishment at school | [] |
| Being teased at school | [] |
| Enjoying food at school | [] |
| Over Eat because of a relationship difficulty with their mother | [] |
| Over Eat because of a relationship difficulty with their father | [] |
| Over Eat due to external cause, e.g. exercise, size of meal | [] |
| Over Eat due to emotional cause | [] |

Q4 continued

Feeling lonely	[]
Feeling guilty	[]
Feeling empty	[]
Feeling out of control	[]
Over Eating is worse when feeling emotional	[]
Over Eating is worse when physical world is unbalanced	[]
Over Eating is worse when bored	[]
Misconception of their weight, e.g. feeling bigger than they were	[]
Professional help, unhelpful	[]
Not enough professional help	[]

CATEGORIES RATING SCALE

Participant No:

Q1 How do participants perceive their early parenting?

- | | |
|---|-----|
| Mother was controlling | [] |
| The parental relationship was of a compliant nature | [] |
| The parents were unavailable emotionally | [] |
| Parents were physically absent for periods of time | [] |
| Women were cautious to share personal material with parents | [] |
| Women could not remember love and affection from parents | [] |
| Father was physically absent at mealtimes | [] |
| Women experienced rules at mealtimes | [] |
| Women experienced parents dictating food intake | [] |
| Women felt deprived of food | [] |
| Women experienced secret eating | [] |
| Generational patterns of eating | [] |

Q2 How do participants perceive ongoing relationships with their parents?

- | | |
|---|-----|
| Women experienced their mother as controlling | [] |
| Compliant relationship with mother | [] |
| Avoiding conflict with parents | [] |
| Father emotionally unavailable | [] |
| Skewed perception of women's maturation by father | [] |
| Women feel rejected by father | [] |

Absent support experienced from parents []

Absent physical affection from parents []

Q3 How do women perceive support from significant relationships (other than parents)?

Partner supports them domestically []

Partner supports them emotionally []

Partner does not support women emotionally []

Partner shows love/affection []

Partner shows anger []

Partner does not show anger []

Q4 How do women perceive their relationship with food.

School memories of food []

Secret eating []

Cause of overeating due to relationship with mother []

Cause of overeating due to relationship with father []

Cause of overeating due to life event []

Continue to overeat due to external cause []

Continue to overeat due to emotional (internal) feeling []

Appendix 11

Appendix 11

Respondent validity Study (Pilot participant's)

1. Introduction

Thank you for agreeing to comment on the results of the study. I have formed some ideas and would like to invite you to comment on whether they make any sense to you or not. It is important that you think about your own experience when forming your opinion.

2. The results of the study

a) Controlling mother relationship

Women said they found their relationship with their mother, both in childhood and within their ongoing adult relationship difficult. They described their mother as 'controlling' and 'domineering'.

b) Conflict avoidance.

Women described their early relationship experiences with their family as avoiding upsets and rows. They described not fully expressing anger and other feelings in fear of being reprimanded.

c) Physically and/or emotionally absent father.

Women described a lack of physical and/or emotional contact with their father's:

Physically – fathers either worked late or abroad.

Emotionally – fathers were not interested in them, had no time for a one-one relationship to develop.

d) Lack of open affection

Women described a lack of physical and verbal affection from their parents and felt deprived by this. Many women also described a lack of affection from their partners.

e) Lack of emotional support

Women reported not feeling understood by their partners, although felt practically and financially supported by them.

f) Emotional deprivation

Many women described feeling rejected by their fathers. Additionally, they felt their parents were unavailable emotionally to them. They described feeling 'empty', 'lonely', and 'unsatisfied'.

g) High focus on food

Women described many rules and routines surrounding food in the parental home and at school. They observed particular eating attitudes and behaviours of their parents, for example, their mother's secret eating pattern, their father being diabetic, food being used as a reward or punishment, and particular timing and routines of food within the home environment.